Supreme Court, U.S.
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No. _____

IN THE

Supreme Court Of The United States

October Term, 1994

ST. FRANCIS MEDICAL CENTER,

Petitioner,

v.

DONNA E. SHALALA, Secretary of Health and Human Services, BRUCE C. VLADECK, Administrator, Health Care Financing Administration; and IRWIN KUES, Chairman, Provider Reimbursement Review Board,

Respondents.

Petition For Writ Of Certiorari
To The United States Court of Appeals
for the Third Circuit

PETITION FOR WRIT OF CERTIORARI

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131 pp

THE QUESTIONS PRESENTED FOR REVIEW

This case involves two jurisdictional rulings by the Third Circuit Court of Appeals which have resulted in the dismissal with prejudice of Petitioner's complaint at the pleading stage. *St. Francis I*, 962 F.2d 1110 (3d Cir. 1992) and *St. Francis II*, 32 F.3d 805 (3d Cir. 1994).

The overarching question presented for review is whether the Court of Appeals erred in ruling that *no* tribunal – administrative or judicial – has jurisdiction to review the Secretary's decision denying Petitioner's 1985 "base year" adjustment request, thereby precluding Petitioner from participating in the TEFRA bonus incentive program established by Congress pursuant to the Medicare statute.

The first question presented for review is whether the *St. Francis I* panel erred in ruling that the Provider Reimbursement Review Board (the "PRRB") did not have subject matter jurisdiction over the 1985 "base year" dispute under the Medicare statute -- assertedly on the ground that there is not $10,000 in controversy -- notwithstanding that the 1985 base year adjustment sought by Petitioner would result in the payment of over $1,000,000 worth of TEFRA bonuses and unreimbursed costs in fiscal 1986-92 alone, and would continue to generate similar payments in the future.

The second question presented is whether the *St. Francis II* panel erred in ruling that, pursuant to the Secretary's Rule 12(b)(1) motion, the District Court did not have federal question jurisdiction over the 1985 "base year" dispute – assertedly on the ground that PRRB jurisdiction *might* have once been available in years *following* the 1985 base year – despite questions of fact as to whether such post-base-year relief was ever "genuinely available to provide redress." *Beverly Hospital v. Bowen*, 872 F.2d 483, 486 (D.C. Cir. 1989).

The third question presented is whether the *St. Francis II* panel erred in following other court of appeals' decisions holding that this Court's decision in *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986) is no longer good law.

PARTIES

All parties hereto are listed in the caption. St. Francis' parent company is St. Francis Health System. St. Francis has no subsidiaries required to be identified pursuant to Supreme Court Rule 29.1. St. Francis and its parent are not-for-profit corporations organized under the laws of the Commonwealth of Pennsylvania.

The Secretary of Health & Human Services is hereinafter referred to as the "Secretary."

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OFFICIAL REPORTS OF OPINIONS IN THE CASE

On April 24, 1992, the Court of Appeals issued an Opinion -- with Judge Scirica dissenting -- denying PRRB subject matter jurisdiction over the 1985 "base year" dispute under 42 U.S.C. § 1395oo(a), assertedly on the ground that there was not $10,000 in controversy -- notwithstanding that the requested 1985 base year adjustment would result in the payment of over $1,000,000 worth of TEFRA bonuses and unreimbursed costs in fiscal 1986-92 alone, and would continue to generate similar payments in the future. However, the Court of Appeals remanded the case to the District Court to permit St. Francis "to file an application for leave to amend its complaint to assert a 28 U.S.C. § 1331 basis for this action." The 1992 Opinion of the Court of Appeals is reported at 962 F.2d 1110. (The quoted language appears at page 1117.) The 1992 Opinion of the Court of Appeals is referred to herein as "*St. Francis I*." *See* Supreme Court Appendix annexed hereto ("Sup. Ct. App.") at A-21.

On August 9, 1994, the Court of Appeals issued an Opinion denying District Court subject matter jurisdiction over the 1985 "base year" dispute under 28 U.S.C. § 1331. That Opinion is reported at 32 F.3d 805. The 1994 Opinion of the Court of Appeals is referred to herein as "*St. Francis II*." Sup. Ct. App. at A-1.

JURISDICTION OF THIS COURT

St. Francis II was decided on August 9, 1994, and judgment was entered that date. Rehearing was denied on September 27, 1994. The Petition for Rehearing In Banc was timely filed under both Fed. R. App. P. 35(b) and 40, and specifically sought rehearing of both *St. Francis I* and *St. Francis II*. The Court of Appeal's September 27, 1994 ruling made clear that both the Rule 40 and the Rule 35 applications were addressed by the Court. *See* Sup. Ct. App. at A-67. Accordingly, the time for filing this Petition for Certiorari commenced running on Sep-

tember 27, 1994. *See* Sup. Ct. R. 13.4. This Court has jurisdiction hereof pursuant to 28 U.S.C. § 1254(1).

This Court has appellate jurisdiction to review both *St. Francis I* and *St. Francis II*. Both *St. Francis I* and *St. Francis II* derive from a single case in the District Court, Docket No. 89-2452 (W.D. Pa.). Under these circumstances, this Court has appellate jurisdiction to "consider questions raised on the first appeal, as well as 'those that were before the court of appeals upon the second appeal.'" *Mercer v. Theriot*, 377 U.S. 152, 153 (1964) (citation to quoted case omitted). *See* Stern, Gressman & Shapiro *Supreme Court Practice* 289 (7th ed. 1993); *Air Line Pilots Ass'n v. UAL Corp.*, 897 F.2d 1394, 1397 (7th Cir. 1990). *See also Arizona v. California*, 460 U.S. 605, 618 (1983).

THE CONSTITUTIONAL PROVISIONS, STATUTES AND REGULATIONS INVOLVED IN THIS CASE

Substantive Provisions

This case involves the Fifth Amendment to the United States Constitution, which provides in pertinent part as follows:

> No person shall be . . . deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

This case also involves 42 U.S.C. § 1395ww(b)(1)(A), which provides in pertinent part as follows:

> (1) [I]f the operating costs of inpatient hospital services . . . of a hospital . . . for a cost reporting period subject to this paragraph --
>
> > (A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A [42

> USCS §§ 1395c et seq.] on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus –
>
> > (i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or
> >
> > (ii) 5 percent of the target amount, whichever is less; . . . .

This case also involves 42 U.S.C. § 1395ww(b)(4)(A), 42 C.F.R. § 413.40(g), (h), and (i) and 42 C.F.R. § 413.86(e), which are set forth in the Appendix hereto.

Subject Matter Jurisdiction Provisions

This case involves 42 U.S.C. § 1395oo(a), which is set forth in the Appendix annexed hereto. This case also involves 28 U.S.C. § 1331, which provides as follows:

> The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

STATEMENT OF THE CASE

Statutory and Regulatory Background

St. Francis participates as a "provider" of services under Part A of the Federal Medicare Program pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*

The Medicare statute evolved from a cost-based retrospective reimbursement system (1966-82), to the reimbursement system known as TEFRA (which is an abbreviation for the Tax Equity and Fiscal Responsibility Act of 1982), to the Prospective Payment System ("PPS") of reimbursement in effect today. Under PPS, providers are not reimbursed based upon their individual costs but instead are reimbursed based on prospectively determined rates generally applied to all hospitals.

Although PPS has largely supplanted TEFRA, the Medicare program provides that certain types of hospitals, as well as "distinct part units" of hospitals, are excluded from PPS. 42 C.F.R. §§ 412.23, 412.25, 412.27 and 412.29. The claims at issue here all involve a distinct part rehabilitation unit subject to the TEFRA reimbursement program.

Three Medicare concepts -- average base year costs per case, TEFRA "target amounts" or ceilings, and TEFRA incentives -- are at the heart of this case and are closely linked. As shown below, through TEFRA, Congress modified the then existing Medicare program in order to provide hospitals with financial incentives -- often referred to as TEFRA bonus incentives -- to render services more economically.

Without an accurate calculation of a hospital's base-period costs, it is not possible to calculate correctly either the "target amounts" or the TEFRA bonuses, which are the keystone of the incentive structure upon which the statute is premised. *See* 42 U.S.C. § 1395ww(b)(3)(A) and 1395ww(b)(1)(A). The Court of Appeals for the District of Columbia explained this concept as follows:

> *TEFRA amended the Social Security Act to slow down the increase in hospital costs and generally improve the fiscal condition of the Medicare program.* Specifically, TEFRA established a new, separate, interim control on hospital cost increases. *It required the Health Care Financing Administration ("HCFA") to provide incentives to hospitals that kept their costs below a "target amount"* and to penalize those that exceeded their target amounts. *A hospital's target amount was based on the allowable operating costs for inpatient hospital services during the "base year"* -- that is, the year *before* [emphasis by D.C. Circuit] the first year subject to TEFRA, *see* 42 U.S.C. § 1395ww(b)(3)(A) (1988). *In other words, in order*

> *to determine the costs for which a particular hospital would be reimbursed in a given year, it was necessary to know what the "allowable operating costs of inpatient hospital services" were for the "base year." The more costs that were deemed "allowable" in the base year, the more a hospital would be reimbursed in subsequent years for those same costs.*

Tucson Medical Center v. Sullivan, 947 F.2d 971, 974 (D.C. Cir. 1991) (emphasis added except as noted).

As further explained in *Sacred Heart Medical Center v. Sullivan*, 958 F.2d 537 (3d Cir. 1992):

> *Under this system, hospitals were obligated to absorb operating costs in excess of their target amounts, but they received bonuses if their operating costs were less than their targeted amounts. Section 1395ww(b)(1)(A).*

958 F.2d at 540 (emphasis added). The incentives set out in § 1395ww(b)(1)(A) are equal to "(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or (ii) 5 percent of the target amount, whichever is less."

A provider is informed of its "target amount" via a notice which is called a Notice of Program Reimbursement or "NPR." 42 C.F.R. § 405.1803. When appropriate, revised NPRs are issued by the Secretary. Here, St. Francis has sought a 1985 base year adjustment because such an adjustment to the base year costs would require the Secretary to issue revised NPRs for *every* year following the base year, commencing with the first year in which the "distorting" events took place, *i.e.*, fiscal 1986, and continuing to the present. With respect to years as to which there is not yet an original NPR, the requested base year adjustment -- if granted -- would determine the "target amount" set forth in the original NPRs when they are issued.

Because of the importance of the base year calculation to the entire structure of the TEFRA statute, base year adjustments are mandated by 42 U.S.C. § 1395ww(b)(4)(A). The Ninth Circuit Court of Appeals has held that, under 42 U.S.C. § 1395ww(b)(4)(A), the Secretary must grant "adjustments to the *base-year* costs," not merely "adjustments to the final reimbursement rate," when changed circumstances after the base year cause "a distortion" between the base year and later years. *Community Hospital of Chandler, Inc. v. Sullivan*, 963 F.2d 1206, 1213-14 (9th Cir. 1992) (emphasis in original), citing 42 U.S.C. § 1395ww(b)(4)(A).

The Ninth Circuit's decision in *Chandler* regarding the operation of 42 U.S.C. § 1395ww(b)(4)(A) is of significance here for two additional reasons. First, the Ninth Circuit's *Chandler* decision records an important concession made by counsel for the Secretary at an oral argument on February 11, 1992: "At oral argument . . . the Secretary acknowledged that regulations that clarify the procedure for requesting adjustment under 42 U.S.C. § 1395ww(b)(4)(A) have not yet been promulgated." *Chandler*, 963 F.2d at 1214 n.4. In *Chandler*, the Ninth Circuit also expressly found that "the Secretary ha[d] frustrated the Congressional intent embodied in" § 1395ww(b)(4)(A). *Chandler*, 963 F.2d at 1214. As discussed below at page 26, the Secretary contends that *Chandler* has no applicability to this case.

St. Francis submits that counsel for the Secretary at the oral argument in *Chandler* was correct. The Secretary's regulations, 42 C.F.R. § 413.40(g), (h), and (i), did not and do not "clarify" the procedure for requesting a base year adjustment under § 1395ww(b)(4)(A).

Facts Pertinent To This Case

The facts pertinent to this case are not complicated. St. Francis operates a distinct part rehabilitation unit subject to TEFRA, not PPS. The base year for the rehabilitation unit is

fiscal 1985, which is the fiscal year ending June 30, 1985. St. Francis experienced significant "distorting" events in fiscal 1986, *i.e.*, the first year after the 1985 base year. As a result of these distorting events, the 1985 base year costs were no longer representative of Petitioner's actual costs in all years following the base year.

For purposes of this Petition, it is not necessary to explain in depth the nature of the 1986 distorting events, other than to say that the distorting events were of a permanent nature and involved (a) the addition of new physical plant facilities, and (b) the discontinuation in fiscal 1986 (at the insistence of the Secretary) of services to certain "short length-of-stay" types of patients, thereby dramatically increasing patient-average-length-of-stay in fiscal 1986 and each year thereafter. *See St. Francis I*, 962 F.2d at 1112-13.

St. Francis has now spent eight years mired in appeals related to the 1985 base year in an ongoing attempt to obtain a base year adjustment to reflect the 1986 distorting events. St. Francis filed its base year adjustment request pursuant to what was then 42 C.F.R. § 413.40(h), which appeared to be the regulation most-closely geared for such requests. *St. Francis I*, 962 F.2d at 1113. (§ 413.40(h) has now been consolidated into §413.40(g).)

St. Francis sought a base year adjustment because a base year adjustment is the only mechanism which will enable St. Francis to qualify for TEFRA bonus incentives in years following the base year. Indeed, the Secretary has conceded that there is *no* post-base-year administrative remedy which would enable St. Francis to obtain TEFRA bonuses in fiscal 1986 (which for that year alone will exceed $50,000 if the 1985 base year adjustment is granted). Moreover, as discussed below at pp. 25-26, there are *acknowledged* questions of fact as to whether the Secretary has "always authorized" post-base-year remedies which were "permanent" in nature *and* which were intended by

the Secretary to result in the payment of TEFRA bonus incentives. The Court of Appeals apparently was not concerned by this potential forfeiture or by these disputed questions of fact. *See St. Francis II*, 32 F.3d at 813, 814.

St. Francis also sought a base year adjustment because the TEFRA statute clearly dictated that the "base year" costs controlled the TEFRA "target amounts," which in turn controlled both reimbursement amounts and the potential award of TEFRA bonuses. In short, St. Francis appealed the "base year" because the "base year" is the cornerstone of the statutory framework. And, at the time, it seemed inconceivable that -- as has happened here -- *no* tribunal would be found to have subject matter jurisdiction over the "base year." Moreover, an appeal of the "base year" appeared to be by far the most efficient remedy because a *single* 1985 base year adjustment would obviate the filing of repetitive, expensive and time-consuming administrative appeals in every year following the base year.[1]

St. Francis did not seek to "rebase" the rehabilitation unit using 1986 as the new base year. St. Francis did not do so because the Secretary and her agents repeatedly informed St. Francis that an appeal of the 1986 cost year could only result in an "exception" to the TEFRA ceilings and could *not* be used as a mechanism to "request a revision to the base year cost per discharge" and also could not be used as a mechanism for "seeking an incentive payment . . . ." Third Circuit *St. Francis II* J.A. at 16 (6/18/87 Letter from Fiscal Intermediary to St. Francis), and J.A. at 22. Moreover, it is now undisputed that "rebasing" is not authorized under either the statute or the applicable regulations for any fiscal year that commences prior

[1] Given the tortured eight-year history of this case, St. Francis has had no choice but to file appeals of each and every year following the base year. Many of those appeals are still pending (for cost years 1989 and forward). As discussed below, St. Francis submits that only a 1985 base year adjustment will afford full relief and also function as a sword that will cut through this administrative Gordian knot.

to April 1, 1990. 42 U.S.C. § 1395ww(b)(4)(A) (as amended); 42 C.F.R. § 413.40(i); *St. Francis II*, 32 F.3d at 813.

Procedural History

Initially, St. Francis petitioned its Fiscal Intermediary, Blue Cross of Western Pennsylvania -- which is an agent of the Secretary -- for a 1985 base year adjustment. Third Circuit *St. Francis II* J.A. at 10. As set out above, the Fiscal Intermediary informed St. Francis that St. Francis had no basis for requesting "a revision to the base year cost per discharge." Third Circuit *St. Francis II* J.A. at 16.[2] The Secretary ultimately "denied the base year cost adjustment claim . . . ." 962 F.2d at 1113.

St. Francis then sought the 1985 base year adjustment before the PRRB, challenging the methodology employed by the Secretary in reviewing such request. As discussed above at page 7, the request was made pursuant to 42 C.F.R. § 413.40(h).

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[2] The Fiscal Intermediary took the position that the only relief available to St. Francis was an "exception to the cost limits for the year ended June 30, 1986 . . . ." Third Circuit *St. Francis II* J.A. at 16. This, of course, involved an appeal of the 1986 cost report. St. Francis followed this portion of the Fiscal Intermediary's directions and ultimately obtained such an "exception," granting full cost reimbursement (but *no* TEFRA bonuses). In their Settlement Agreement, however, the parties agreed that the question of TEFRA bonus payments for fiscal 1986 would await the outcome of the 1985 base year adjustment request filed pursuant to 42 C.F.R. § 413.40(h). *See St. Francis II*, 32 F.3d at 808 n.3 ("The parties make no agreement with respect to the appropriateness of any TEFRA incentive payments or other payments in excess of final audited costs should an adjustment be awarded under 42 C.F.R. 413.40(h)".). Because St. Francis had received what it understood to be the "full relief" available from the Secretary under the 1986 appeal, and indeed the Secretary so stated, *see* discussion in note 6 of this Petition, St. Francis voluntarily dismissed the 1986 appeal, *see* 32 F.3d at 808 n.3, and continued its efforts to obtain a base year adjustment via its 1985 appeal. As discussed below, the Secretary now contends that St. Francis should *not* have requested a 1986 "exception" but instead should have used the 1986 appeal as the method for obtaining so-called "permanent base-period relief," but St. Francis denies that any such administrative remedy existed in 1986.

The PRRB ruled that St. Francis did not meet the $10,000 amount in controversy requirement for jurisdiction. Sup. Ct. App. at A-65. *See also* Third Circuit *St. Francis II* J.A. at 18, 32 and *St. Francis I*, 962 F.2d at 1113.

St. Francis next filed its Original Complaint in the District Court for the Western District of Pennsylvania challenging the denial of jurisdiction. St. Francis alleged that the PRRB did have subject matter jurisdiction over the base year adjustment request, pursuant to 42 U.S.C. § 1395oo(a). The District Court agreed, ruling that the PRRB could look to the *effect* of the base year adjustment, which would *automatically* generate amounts at issue in subsequent years -- for example, TEFRA incentive payments -- to establish jurisdiction over the base year. *See* Sup. Ct. App. at A-57, quoted in *St. Francis II*, 32 F.3d at 808.

The Secretary appealed, arguing that *only the 1985 year was at issue and that the PRRB could examine only the 1985 base year to establish jurisdiction. See St. Francis I*, 962 F.2d at 1114 ("*The Secretary argues that* this 'amount in controversy' requirement may not be met by including the reimbursement due to the Medical Center in the 1986-88 period because *the dispute here relates only to the 1985 cost report.*") (emphasis added).

In an opinion by Judge Seitz (joined by Judge Alito), the Court of Appeals concluded that the PRRB lacked jurisdiction over the 1985 base year because St. Francis was not seeking any additional reimbursement in the base year. Thus, according to the majority, there was not $10,000 in controversy, as required by 42 U.S.C. § 1395oo(a). *See St. Francis I* (annexed hereto at pp. A-21 to A-38 and reported at 962 F.2d 1110). Judge Scirica dissented, stating that even though no base year reimbursement was at issue, this was not dispositive: "It seems to me that the amount in controversy analysis in requests for such base year cost adjustments necessarily includes subsequent years, because the *effect* of granting the adjustment would be to increase

reimbursable costs in subsequent years." 962 F.2d at 1118 (dissenting opinion) (emphasis in original).

Having concluded that the PRRB lacked jurisdiction over the base year under 42 U.S.C. § 1395oo(a), the majority remanded the case "to the district court to permit the Medical Center to file an application for leave to amend its complaint to assert a 28 U.S.C. § 1331 basis for this action." 962 F.2d at 1117. Judge Scirica concurred in this portion of the ruling, stating: "I concur in the majority's decision to remand this case to allow the Medical Center to assert 28 U.S.C. § 1331 as a basis for jurisdiction in the district court." *Id.*

On remand, St. Francis filed an Amended Complaint asserting § 1331 jurisdiction in the District Court. The "amended complaint sought essentially the same relief as [Petitioner's] prior complaint." *St. Francis II*, 32 F.3d at 809.

The Secretary moved to dismiss, arguing that 42 U.S.C. §§ 405(h) and 1395ii precluded § 1331 jurisdiction. St. Francis filed an opposition, arguing that, under this Court's *Michigan Academy* decision, §§ 405(h) and 1395ii did not preclude § 1331 jurisdiction. *See Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). In its brief, St. Francis also demonstrated that base year adjustments are mandated by the applicable statute, 42 U.S.C. § 1395ww(b)(4)(A), and further demonstrated that the adjustment process was clearly intended to result in the payment of TEFRA bonuses (notwithstanding the Secretary's longstanding position to the effect that adjustments awarded under § 1395ww(b)(4)(A) could *never* result in the payment of TEFRA bonus incentives). See discussion below at page 12 and at page 27.

At this point, the Secretary filed a reply brief asserting -- for the first time in the multi-year history of the dispute -- "the Secretary's interpretation of [42 C.F.R.] section 413.40(g)(1) as *potentially* authorizing base period adjustments premised on cost years *after* the base period." Third Circuit *St. Francis II*

J.A. at 275 (1/11/93 Reply Brief at 15 (emphasis added)). The Secretary also contended -- again for the first time -- that permanent post-base year relief would "enhance" St. Francis' "prospects" of receiving TEFRA incentive payments. Third Circuit *St. Francis II* J.A. at 263, (1/11/93 Reply Brief at 3). *But compare* the Secretary's 1988 statement at 53 Fed. Reg. 9337, 9340 (March 22, 1988), as corrected in 53 Fed. Reg. 12641 (April 15, 1988) (quoted below at pages 26-27 of this Petition, and stating that § 1395ww(b)(4)(A) adjustments could *not* give rise to the payment of TEFRA incentives under § 1395ww(b)(1)(A)).

St. Francis strongly disputed the Secretary's newly-proffered contentions, arguing that they were merely "convenient litigating positions" intended to defeat St. Francis' legitimate claims for a base year adjustment -- under Section 1395ww(b)(4)(A) -- which would lead automatically to new TEFRA ceilings in every year after the base year -- under Section 1395ww(b)(3)(A) -- thereby enabling St. Francis to qualify for TEFRA bonuses -- under Section 1395ww(b)(1)(A) -- in the years following the base year (commencing with fiscal 1986). *See Bowen v. Georgetown University Hospital*, 488 U.S. 204, 212-13 (1988) ("Deference to what appears to be nothing more than an agency's convenient litigating position would be entirely inappropriate").

St. Francis pointed out to the District Court that, in *St. Francis I*, the Court of Appeals had ruled that post-base-year cost reports could *not* be looked to in order to *confer* jurisdiction on the PRRB. Accordingly, Petitioner argued, so long as *St. Francis I* remained "law of the case," the Secretary should not be permitted to point to purported post-base-year administrative remedies in order to *deprive* the District Court of § 1331 jurisdiction over the 1985 cost report (*i.e.*, what is sauce for the goose is sauce for the gander). St. Francis also disputed that there was any such thing as "permanent base period cost relief" (using

post-base year appeals) in existence at the time St. Francis was appealing its 1986 cost report. *See* footnote 7 at page 25 below.

With regard to the so-called "enhanced prospects" of receiving TEFRA incentives, St. Francis pointed out that the Secretary had expressed a contrary position in 1988. See discussion at pages 26-27 of this Petition. St. Francis also argued that "prospects" are not a substitute for the *guaranteed* payments that would flow from a 1985 base year adjustment. St. Francis also argued that the Secretary had, in fact, never authorized any post-base-year adjustments -- to any provider in the country -- which resulted in a hospital obtaining TEFRA bonus payments.

According to St. Francis, these "factual" disputes regarding what administrative remedies were previously available for post-base-year appeals precluded granting the Secretary's Rule 12(b)(1) motion. The Magistrate Judge nevertheless accepted at face value the Secretary's argument that St. Francis had post-base year administrative remedies and that for this reason the federal courts lacked § 1331 federal question jurisdiction over the base year. The District Court adopted the Report and Recommendation without change, and the Third Circuit affirmed. *See St. Francis II*, 32 F.3d 805 (Sup. Ct. App. at A-1).

THE REASONS FOR GRANTING THE WRIT

When read together, the two panel decisions in this case -- *St. Francis I* and *St. Francis II* -- stand for the following proposition: No tribunal -- *i.e.*, neither the PRRB nor the federal district courts -- has subject matter jurisdiction over St. Francis' 1985 base year for purposes of awarding a base-year adjustment pursuant to 42 U.S.C. § 1395ww(b)(4)(A).

Given the central importance of the "base year" concept under the Medicare statute, the Court of Appeals has created a significant jurisdictional vacuum. Moreover, in refusing to grant base year adjustments, the Secretary has inappropriately excluded St. Francis from participation in the TEFRA bonus

program established by Congress in 42 U.S.C. § 1395ww(b)(1)(A).

Without a base year adjustment, the Secretary has conceded that St. Francis can never qualify for a TEFRA bonus payment in fiscal 1986 (which for that year alone would exceed $50,000). More importantly, however, with regard to *all the cost years after 1986*, the Court of Appeals acknowledged that there were disputed questions of fact as to whether an adequate post-base-year remedy for obtaining TEFRA bonuses had ever existed. Nevertheless, the Court of Appeals ruled that St. Francis was not permitted to continue its eight-year quest for a base year adjustment, assertedly because *no* tribunal has subject matter jurisdiction over the 1985 base year.

St. Francis respectfully submits that the writ should be granted for the following reasons:

First, the *St. Francis I* panel wrongly decided an important question of federal law which has not been, but should be, settled by this Court. The PRRB *does* have jurisdiction over base year adjustment requests. *See* Sup. Ct. R. 10.1(c).

Second, the *St. Francis II* panel departed from the accepted and usual course of judicial proceedings (or sanctioned such a departure by a lower court) by affirming the dismissal of the § 1331 claims pursuant to the Secretary's Rule 12(b)(1) motion, notwithstanding that there are disputed questions of fact as to whether a § 1395oo(a) remedy was ever "genuinely available to provide redress" to St. Francis. *Beverly Hospital v. Bowen*, 872 F.2d 483, 486 (D.C. Cir. 1989) (when the § 1395oo route is not "genuinely available to provide redress," the "parties may invoke general federal question jurisdiction, 28 U.S.C. § 1331 . . . ."). St. Francis submits that the Secretary did not provide St. Francis with a "genuinely available" remedy which would have enabled St. Francis to obtain "base year" relief, which would, in turn, have resulted in an award of TEFRA incentives to St. Francis. *See* Sup. Ct. R. 10.1(a). Alternatively, by failing to

follow *Beverly Hospital*, the Court of Appeals created a conflict in the circuits. *See* Sup. Ct. R. 10.1(a).

Third, the *St. Francis II* panel decided a federal question in a way that conflicts with an applicable decision of this Court, *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). St. Francis submits that the panel decision in *St. Francis II* -- along with the recent pronouncements by other courts of appeal to the effect that *Michigan Academy* is no longer good law -- were all are in error. *See* Sup. Ct. R. 10.1(c).

Accordingly, St. Francis submits that either *St. Francis I* or *St. Francis II* is wrongly decided.

I. *ST. FRANCIS I* SHOULD BE OVERTURNED BECAUSE THE COURT OF APPEALS WRONGLY DECIDED AN IMPORTANT QUESTION OF FEDERAL LAW WHICH HAS NOT BEEN, BUT SHOULD BE, SETTLED BY THIS COURT

In *St. Francis I*, Petitioner reasoned that either (a) the "amount" of the requested base year adjustment (which exceeded $700,000), or (b) its *effect* in the form of increased reimbursement amounts and TEFRA incentives that would be paid in later years as a direct result of the base year adjustment (in excess of $1,000,000 for just the period 1986-92), were properly viewed as the amount in controversy for jurisdictional purposes. The Secretary, however, convinced the Court of Appeals that the PRRB lacked jurisdiction over the 1985 base year adjustment request because (as St. Francis conceded) no actual reimbursement was at issue in that year and, hence, according to the Secretary, there was not "$10,000 in controversy," as required by 42 U.S.C. § 1395oo(a).

In a strong dissent, Judge Scirica reasoned that the huge reimbursement amounts in *later* years automatically occasioned by the adjustment to the 1985 base year costs were clearly

sufficient to satisfy the $10,000 amount in controversy requirement. Judge Scirica reasoned as follows:

> It seems to me that the amount in controversy analysis in requests for such base year cost adjustments necessarily includes subsequent years, because the *effect* of granting the adjustment would be to increase reimbursable costs in subsequent years. Reimbursements in the base year would not be affected, because the adjustment is to "the amount of the operating costs considered in establishing cost per case" -- *not* to the amount of operating costs actually reimbursed in the base year.

962 F.2d at 1118 (dissenting opinion) (emphasis in original).

St. Francis submits that Judge Scirica was correct. The hypothetical base year adjustment will automatically result in the issuance of revised NPRs -- or, for more recent years, original NPRs -- awarding the payment of millions of dollars in the years *following* the base year (commencing with fiscal 1986 and continuing indefinitely into the future). Thus, there is more than "$10,000 in controversy" in this case. Moreover, even if the Secretary were to prevail in her argument that no revised NPRs can be issued for the currently closed cost years 1986-88, a 1985 base year adjustment would concededly result in the issuance of revised NPRs for the cost years with still pending appeals, *i.e.*, 1989-92, and those appeals implicate hundreds of thousands of dollars. Finally, a 1985 base year adjustment will also concededly control the issuance of original NPRs for all years as to which no NPR has yet been issued. Accordingly, St. Francis respectfully requests that this Court reverse *St. Francis I* for the reasons set forth in Judge Scirica's dissenting opinion.

Significantly, it now appears the Secretary may have *known* -- in 1991, when *St. Francis I* was being briefed and argued -- that Judge Scirica was correct. St. Francis, however,

did not become aware of the basis for the Secretary's knowledge until February of 1994.

In February, 1994, in the course of preparing for oral argument in *St. Francis II*, counsel for St. Francis noted that the Secretary's Brief (in the *St. Francis II* appeal) cited a District Court opinion (which had been reversed on appeal on other grounds) for a "history of 42 U.S.C. § 1395oo." Specifically, the Secretary's Brief stated as follows:

> Thus, the *Michigan Academy* exception plainly does not apply to Part A provider reimbursement cases like this one, *which have been reviewable under the Medicare statute's exclusive provisions since 1972.*

Secretary's 11/1/93 *St. Francis II* Brief at 33, (emphasis added), citing *Methodist Hospitals of Memphis v. Sullivan*, 799 F. Supp. 1210 (D.D.C. 1992), *rev'd on other grounds, Administrators of Tulane Educational Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 114 S. Ct. 740 (1994).

This sentence from the Secretary's *St. Francis II* Brief had an "odd ring" to it -- the Secretary appeared to be espousing *exactly* the position that St. Francis had taken in *St. Francis I*, *i.e.*, that the 1985 base-year adjustment request *was* appealable to the PRRB. Accordingly, even though the oral argument in the second appeal was focused on jurisdiction under 28 U.S.C. § 1331, not 42 U.S.C. § 1395oo, counsel for St. Francis decided to review *Methodist Hospitals* and *Tulane*.

On first reading, *Methodist Hospitals* appeared to have nothing whatever to do with this case. *Methodist Hospitals* involved a dispute relating to Medicare graduate medical education ("GME") payments, and GME costs are not at issue in this case. However, because *Methodist Hospitals* contained a discussion regarding revisions to "base-year" GME costs and because the Secretary had cited *Methodist Hospitals* as authority for appeals under § 1395oo, counsel for St. Francis took a

"second" look at the appellate review mechanisms described in *Methodist Hospitals*. What she found is set forth below.

The *Methodist Hospitals* and *Tulane* opinions make clear that the GME "base-year" statute enacted by Congress in 1986 presented the Secretary with a problem. The Secretary did not want allegedly inappropriate cost figures for providers' 1984 base years "to be 'cemented' into the base period amount and indefinitely carried forward in the formula for future reimbursements." *Tulane*, 987 F.2d at 792. On the other hand, the base-year cost reports were -- for the most part -- closed. (This is similar to Petitioner's predicament, except here it is undisputed that Petitioner filed a *timely* appeal of its 1985 cost report.)

To circumvent this problem, the Secretary issued 42 C.F.R. § 413.86(e)(1)(iii), which authorized the Secretary's fiscal intermediaries to modify the closed cost reports, but also provided that the Secretary's fiscal intermediaries could "'modify the hospital's GME base-period costs *solely* for purposes of computing the per resident amount,' and not to adjust the amount owed under the 1984 [base-year] NPR." *Tulane*, 987 F.2d at 793, quoting 54 Fed. Reg. 40,301 (emphasis added by Court of Appeals). Finally, "hospitals were given 180 days to appeal any determination of their base period per resident amount." *Tulane*, 987 F.2d at 793, citing 42 C.F.R. § 413.86(e)(1)(v). It is undisputed that such appeals go to the PRRB. *See Methodist Hospitals*, 799 F. Supp. at 1212.[3]

In issuing 42 C.F.R. §§ 413.86(e)(1)(iii) and 413.86(e)(1)(v) in September of 1989, the Secretary set up an

[3] It is worth noting that 42 C.F.R. § 413.86(e)(1)(v) does not state *expressly* that GME appeals should be taken to the PRRB. In September, 1993, however, the Secretary issued Program Instructions clarifying that the appeal process followed in *Methodist Hospitals* was correct. *See* Provider Reimbursement Manual, Chapter 29 (Appendix A) (Transmittal No. 372, issued September 1993). This is one of the "yellow-lined" materials handed up to the Court of Appeals at oral argument on March 4, 1994 and is part of the record in the Court of Appeals. *See* note 5 below.

appeal procedure authorizing appeals to the PRRB of GME base-year disputes even though no payments (or recoupments) of reimbursement amounts were at issue for the closed base-year cost reports. Because it is undisputed that these appeals take place pursuant to 42 U.S.C. § 1395oo (*see, e.g., Tulane*, 987 F.2d at 792, *see also* Secretary's 11/1/93 Brief in *St. Francis II* at 33, quoted above) and because subject matter jurisdiction can never be conferred by "consent" of the parties, the Secretary apparently believed -- at the time the GME regulations were issued in 1989 -- that the PRRB had subject matter jurisdiction over the GME base-year appeals, even though those appeals did not implicate *any* reimbursement in the 1984 base-year cost reports which were being appealed. However, it is undisputed that the GME appeals to the PRRB were subject to the $10,000 amount in controversy requirement of § 1395oo(a).

St. Francis submits that the jurisdictional concepts embodied in the Secretary's 1989 GME regulations are inconsistent with the holding in *St. Francis I* and with the position advocated by the Secretary during the course of the 1991 briefing in *St. Francis I*, where the Secretary argued as follows:

> The Medicare statute plainly requires an amount in controversy of "$10,000 or more" "as to the amount of total program reimbursement due the provider." 42 U.S.C. § 1395oo(a)(1)(A)(i), (2). Plaintiff states, however, that "[b]eing hypothetical, the base year adjustment does not implicate program reimbursement due the provider in the base year." MC Brf. at 40. On the provider's own account, then, its suggested "*hypothetical* base year adjustment figure" is a strictly hypothetical number that could not affect program reimbursement, and hence could not satisfy the statutory requirement of a *bonafide* (not "hypothetical") amount in controversy "as to the amount of

> total program reimbursement." 42 U.S.C. § 1395oo(a)(1)(A)(i).

Third Circuit *St. Francis II* J.A. at 179 (Reply Brief for the Secretary in *St. Francis I* at 13 (emphasis added by the Secretary)). (Over the objection of the Secretary, Petitioner included the *St. Francis I* appellate briefs in the *St. Francis II* Appendix.)

The *St. Francis I* appeal was argued on December 10, 1991 and decided on April 24, 1992. In an opinion written by Judge Seitz, the Court of Appeals ruled as follows:

> § 1395oo(a) limits a provider's request for a Board hearing to claims that could result in reimbursement of $10,000 or more due the provider *under the cost report in dispute*.

St. Francis I, 962 F.2d at 1114 (emphasis added).

It is significant that Judge Seitz did not limit his analysis to the statute itself. Rather, Judge Seitz went on to point out that, to the extent the statute did not on its face "clearly deny the Board jurisdiction," the Court of Appeals was relying on the Secretary's interpretation of her own regulations. *Id.* at 1115. Judge Seitz explained his reliance on the Secretary's regulations at pages 1115-16 of his opinion. Judge Seitz then concluded:

> Thus, even if the statutory provision is considered to be unclear and we are thereby able to resort to these regulations for enlightenment, we conclude that they would compel the same conclusion we have reached in interpreting the language of the statute.

Id. at 1116. In short, in *St. Francis I* the Court of Appeals appeared to rely on the Secretary's regulatory scheme for "enlightenment" in interpreting the statute, but the Secretary *failed to disclose* all aspects of her regulatory scheme, namely her 1989 GME regulations.

St. Francis submits that the Secretary's GME regulations shed additional "light" on the jurisdictional issue decided in *St. Francis I*. St. Francis further submits that the Secretary's GME regulations demonstrate that the decision in *St. Francis I* was clearly erroneous and will work a manifest injustice if it is permitted to stand. Deference to the Secretary's interpretation of § 1395oo(a) is not appropriate here because she has adopted a "convenient litigating position." *See Bowen v. Georgetown University Hosp.*, 488 U.S. 204, 212-13 (1988) ("Deference to what appears to be nothing more than an agency's convenient litigating position would be entirely inappropriate").[4]

As set out above, counsel for St. Francis did not unearth the contradictory GME appeal process until 1994. Accordingly, the Secretary may argue that this Court cannot consider the § 413.86(e) argument in ruling upon the *St. Francis I* appeal. Here, however, St. Francis is not asserting a new statutory basis for subject matter jurisdiction. St. Francis also is not asserting a new theory as to why jurisdiction exists – St. Francis is simply arguing, as before, that there is $10,000 in controversy in the base year appeal. Moreover, because the Secretary made affirmative representations regarding her Medicare regulations which were inconsistent with the actual Medicare regulations in existence at the time – namely, § 413.86(e) – St. Francis submits that the Secretary is estopped from arguing that it is too late for St. Francis to raise this contradiction in the Secretary's position now.[5]

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[4] Alternatively, if *St. Francis I* were found to be a *correct* statement of the jurisdictional scope of § 1395oo(a), that would call into question the PRRB's subject matter jurisdiction over the *billions* of dollars of GME appeals presently wending their way through the administrative appeal process.

[5] This is particularly true given the fact that St. Francis brought the § 413.86(e) argument to the attention of the Court of Appeals within days of St. Francis' discovery of the issue. Specifically, after discovering the issue while preparing for oral argument in *St. Francis II*, counsel for St. Francis handed up to the Court of Appeals at oral argument on March 4, 1994

II. IN *ST. FRANCIS II*, THE COURT OF APPEALS DEPARTED FROM THE ACCEPTED AND USUAL COURSE OF JUDICIAL PROCEEDINGS BY AFFIRMING THE DISMISSAL OF THE SECTION 1331 CLAIMS PURSUANT TO A RULE 12 MOTION, NOTWITHSTANDING THE ACKNOWLEDGED EXISTENCE OF DISPUTED QUESTIONS OF FACT

In *St. Francis I*, the Secretary argued that § 1395oo(a) jurisdiction did not exist because it was *impermissible to look at future cost years* in order to confer PRRB jurisdiction over the base year. The Court of Appeals summarized the Secretary's argument as follows:

> *The Secretary argues that* this "amount in controversy" requirement may not be met by including the reimbursement due to the Medical Center in the 1986-88 period because *the dispute here relates only to the 1985 cost report.*

St. Francis I, 962 F.2d at 1114 (emphasis added). However, in *St. Francis II*, the Secretary did an "about face" and argued that § 1331 jurisdiction did not exist because it was *mandatory to*

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yellow-lined copies of § 413.86(e), *Methodist Hospital, Tulane*, and certain other related materials. (The court reporter has confirmed that these yellow-lined materials are part of the record below.) Thereafter, St. Francis filed a motion seeking leave to brief the § 413.86(e) issue, but that motion was denied by the *St. Francis II* panel in May of 1994. Again, in its Petition for Rehearing In Banc, St. Francis set forth the § 413.86(e) argument and urged the Court of Appeals to reconsider *St. Francis I* in light of the § 413.86(e) argument. Finally, when the Court of Appeals issued its September 27, 1994 Order denying the Petition for Rehearing In Banc, St. Francis immediately noted that Judge Seitz (the author of *St. Francis I*) had not participated in the *in banc* determination. *See* Sup. Ct. App. at A-67. Accordingly, St. Francis made a motion requesting that its Petition for Rehearing In Banc be submitted to all judges who had participated in deciding both *St. Francis I* and *St. Francis II*, but the Court of Appeals (Judge Alito) also denied this motion on October 21, 1994. *See* Sup. Ct. App. at A-69.

look at future cost years in order to defeat District Court jurisdiction over the base year. St. Francis disputes that the Secretary's postulated post-base-year remedies can defeat jurisdiction over the base year. Nevertheless, using this "heads I win, tails you lose" approach, the Secretary managed to convince the Court of Appeals in *St. Francis II* that there was no § 1331 jurisdiction over the *1985* cost year because there *might* once have been effective remedies that could have been awarded by the PRRB in cost years *following* the base year.

Petitioner, on the other hand, submits that there are, at a minimum, disputed questions of fact as to whether adequate post-base-year remedies for the period 1986 through the present have ever been available to St. Francis. Indeed, as shown below, a careful review of *St. Francis II* establishes that even the Court of Appeals was forced to acknowledge the existence of such factual disputes.

It is well established that federal question jurisdiction under 28 U.S.C. § 1331 will lie with respect to a Medicare reimbursement dispute if the 42 U.S.C. § 1395oo route is not "genuinely available." As explained by the Court of Appeals for the District of Columbia:

> The 42 U.S.C. § 1395oo route is indeed exclusive *when it is genuinely available to provide redress; when that is not the case, however, parties may invoke general federal question jurisdiction*, 28 U.S.C. § 1331 . . . .

Beverly Hospital v. Bowen, 872 F.2d 483, 486 (D.C. Cir. 1989).

Beverly Hospital is particularly applicable here because it involved an effort by the Secretary to invoke an administrative remedy *which did not exist at a point in time when the provider could have filed a "timely" application with its fiscal intermediary. See Beverly Hospital*, 872 F.2d at 486 ("The proposed regulation does not explain how an application to the fiscal

intermediary in 1989 for costs incurred in 1984, 1985 and 1986 would be timely."). Similarly the Secretary here is *now* asserting that Petitioner's 1986 claims are time-barred, although at other points in time the Secretary has variously claimed that the 1986 claims are either "moot" or "fatally premature" and hence not "ripe."[6]

The District of Columbia District Court has followed *Beverly Hospital*, stating: "[T]he Secretary cannot relegate providers to a dead-end procedure under the Medicare statute, and then argue that the provider loses because the Medicare statute is the exclusive means of redress. When such bureaucratic red tape strangles a provider's right to judicial review, the Court may invoke its federal question jurisdiction and mandamus power." *Memorial Hospital v. Sullivan*, 779 F. Supp. 1410, 1412 (D.D.C. 1991).

Here, the Court of Appeals *acknowledged* in its *St. Francis II* Opinion that there were disputed questions of fact as to

[6] The Secretary's changing position regarding the *status* of the 1986 fiscal year is revealing (even though the *actual* status has not changed since 1990, when St. Francis dismissed its appeal shortly after the parties entered into their 1990 Settlement Agreement). In the 1991 *St. Francis I* appeal, the Secretary argued that, because St. Francis had obtained reimbursement for 100% of its unreimbursed 1986-88 costs (when St. Francis settled its "exception" appeal), St. Francis had now received "*full relief* for the 1986 through 1988 cost years" and such claims were "now moot." *See* Third Circuit *St. Francis II* J.A. at 119 (Brief for the Secretary in *St. Francis I* at 38). On remand, however, the Secretary told the District Court that the 1986 claims were "fatally premature" and not yet "ripe" for judicial resolution. Third Circuit *St. Francis II* J.A. at 251, 254 (Secretary's 10/1/92 Memorandum at 31, 34). But, on the second appeal, the Secretary shifted gears a third time and argued that the 1986 appeal was time-barred. *See* Secretary's *St. Francis II* Brief at 50 (arguing that Petitioner "either slept on its appeal rights or, for tactical reasons, chose not to timely exercise those rights"). In sum, the Secretary's "litigating position" regarding the status of the 1986 appeal has metamorphosed from a "mootness" argument in 1991, to a "ripeness" argument in 1992, to a "time-barred" argument in 1993, even though the actual status of the 1986 appeal has not changed one wit during that time period.

whether the § 1395oo route had ever been genuinely available to St. Francis. Thus, the Court of Appeals wrote as follows:

> As for a permanent base-period cost adjustment [obtained through an appeal of a year *other than* the base year], SFMC argues that the Secretary has only recently recognized the availability of such relief. Indeed, SFMC charges that the Secretary previously took the position that no such relief was available and that the Secretary's current interpretation of the relevant regulations is simply a "convenient litigating position." The Secretary disputes these charges. *But whether or not SFMC's charges are justified, we do not think they have a bearing on the availability of jurisdiction under 28 U.S.C. § 1331*, for subject matter jurisdiction can never be created by estoppel.

32 F.3d at 813 (emphasis added) (citation omitted) (clarification in brackets supplied).[7]

The ruling of the Court of Appeals turns the Federal Rules of Civil Procedure on their head (and throws the due process clause out the window). The Court of Appeals has ruled, in essence, that *because there is a question of fact regarding the availability of a § 1395oo remedy*, the Secretary is entitled to win her Rule 12(b)(1) motion dismissing Petitioner's § 1331 Amended Complaint *with prejudice*. This ruling "has so far departed from the accepted and usual course of proceedings, or

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[7] St. Francis argued to the Court of Appeals that St. Francis saw no distinction between the Secretary's purported remedy and "rebasing," which all parties concede was *not* available in 1986. See discussion above at pages 8-9. St. Francis also contended that the Secretary had manufactured this purported permanent remedy *very recently* in order to defeat § 1331 jurisdiction. *See, e.g.*, Third Circuit *St. Francis II* J.A. at 119 (Brief of the Secretary in *St. Francis I* at 38 ("[T]he district court erred in holding that it is unreasonable and inefficient to require the provider to file *annually* for exceptions or adjustments to the applicable TEFRA target amount") (emphasis added).

sanctioned such a departure by a lower court," *see* Sup. Ct. R. 10.1(a), that this Court should grant Petitioner's writ. (The only other way to read *St. Francis II* is to conclude that the Third Circuit disagrees with the holding in *Beverly Hospital*, in which event there is a conflict in the circuits which provides a basis for granting the writ. *See* Sup. Ct. R. 10.1(a).)

The existence of questions of fact regarding the remedies that were available to St. Francis in 1986 is further demonstrated by an admission made by the Secretary *in 1992* at oral argument before the Ninth Circuit in *Community Hospital of Chandler, Inc. v. Sullivan*, 963 F.2d 1206 (9th Cir. 1992). In *Chandler*, the Ninth Circuit pointed out that the Secretary made the following concession: "At oral argument, for example, the Secretary acknowledged that regulations that clarify the procedure for requesting adjustment under 42 U.S.C. § 1395ww(b)(4)(A) have not yet been promulgated." 963 F.2d at 1214 n.4. In the courts below, the Secretary adamantly contended that *Chandler* "has no applicability to this case . . . ." *See, e.g.*, Secretary's *St. Francis II* Brief at 45.[8]

The Secretary also claimed that the postulated permanent post-base-period relief could have "enhanced" Petitioner's "prospects" of receiving TEFRA bonuses. *See* discussion above at pp. 11-12. In response, Petitioner argued to the District Court and to the Court of Appeals that this, too, was an inaccurate characterization of the Secretary's prior pronouncements. *See* 53 Fed. Reg. 9337, 9340 (March 22, 1988), as corrected in 53 Fed. Reg. 12641 (April 15, 1988) ("We believe that . . . the exceptions and adjustments provided under section 1886(b)(4) of the Act [codified at 42 U.S.C. § 1395ww(b)(4)] should *not* be used to increase a hospital's incentive payment under section 1886(b)(1)(A) of the

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[8] The Secretary has herself admitted that §§ 413.40(g) and (h) of her regulations "have resulted in confusion." *Redbud Community Hospital v. Blue Cross and Blue Shield Assoc./Blue Cross of California*, (CCH) Medicare and Medicaid Guide ¶ 41,417 (HCFA Admin. Decision, Apr. 26, 1993.)

Act [codified at 42 U.S.C. § 1395ww(b)(1)(A)].) (Emphasis added to the word "not," the addition of which was the "correction" set out at 53 Fed. Reg. 12641.) *See also* Addendum C to the Opening Brief filed by St. Francis in the *St. Francis II* appeal (documenting the undisputed fact that, as late as May of 1992, the Secretary had *never* used the adjustment process to grant TEFRA incentives). *See also Bowen v. Georgetown University Hosp.*, 488 U.S. 204, 212-13 (1988) ("Deference to what appears to be nothing more than an agency's convenient litigating position would be entirely inappropriate").

Petitioner submits that, given these disputed factual issues, it was clearly erroneous to dismiss the Amended Complaint at the Rule 12(b)(1) stage. *See* 2A Moore's *Federal Practice* ¶ 12.07 [2.-1] (2d ed. 1992). *See also American Ambulance Service, Inc. v. Sullivan*, 911 F.2d 901, 903 (3d Cir. 1990) (following *Michigan Academy*).

III. *ST. FRANCIS II* SHOULD BE OVERTURNED BECAUSE IT CONFLICTS WITH THIS COURT'S *MICHIGAN ACADEMY* DECISION

St. Francis II should also be overturned because there is a "methodology" dispute here. Petitioner also has an equal protection claim, based on Petitioner's contention that providers with post-base-year "distorting" events have been unfairly and irrationally excluded from participation in the TEFRA bonus program established by Congress. *See St. Francis II*, 32 F.3d at 809. Thus, the Court of Appeals erred when it declined to follow *Michigan Academy*, wherein this Court reaffirmed "the strong presumption that Congress intends judicial review of administrative action." *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 670 (1986). The Court of Appeals apparently did so on the ground that *Michigan Academy* is no longer good law. *See St. Francis II*, 32 F.3d at 812. *See also id.* at 809, *citing National Kidney Patients Ass'n v. Sullivan*, 958 F.2d 1127, 1130 (D.C. Cir. 1992), *cert. denied*, 113 S. Ct.

966 (1993). *National Kidney* held that *Michigan Academy* was no longer good law in light of the 1986 Amendments to Medicare Part B.

Other courts of appeal have announced the death of *Michigan Academy* based upon the 1986 amendments to Medicare Part B. Thus, the Sixth Circuit has recently concluded: "We reject Dr. Farkas' argument that the amount/methodology distinction of *Michigan Academy* is still good law . . . ." *Farkas v. Blue Cross and Blue Shield of Michigan*, 24 F.3d 853, 860 (6th Cir. 1994). *Accord*, *Abbey v. Sullivan*, 978 F.2d 37 (2d Cir. 1992). *But compare Blue Bell Medical, Inc. v. Pennsylvania Blue Shield*, 775 F. Supp. 829, 833 (M.D. Pa. 1991) ("[T]he distinction the defendants would draw between this case and *Michigan Academy* on the basis of the current availability of judicial review of Part B claims is irrelevant. In fact, *Michigan Academy* itself rebuts it.")

St. Francis submits that the District Court in *Blue Bell*, unlike the various courts of appeal, correctly read this Court's *Michigan Academy* decision. *Michigan Academy* applies *equally* to Part A and Part B disputes under the Medicare statute, so long as the dispute in question relates to "the *method* by which such amounts are to be determined rather than the *determinations* themselves." 476 U.S. at 675 (emphasis in original). Indeed, *Michigan Academy* states this directly:

> The reticulated statutory scheme, which carefully details the forum and limits of review of "any determination . . . of . . . the amount of benefits under part A," 42 U.S.C. § 1395ff(b)(1)(C) (1982 ed., Supp. II), and of the "amount of . . . payment" of benefits under Part B, 42 U.S.C. § 1395u(b)(3)(C), simply does not speak to challenges mounted against the *method* by which such amounts are to be determined rather than the *determinations* themselves.

See Michigan Academy, 476 U.S. at 675 (emphasis and omissions in original). *Accord, McNary v. Haitian Refugee Center, Inc.*, 498 U.S. 479, 498 (1991). *See also Thunder Basin Coal Co. v. Reich*, 114 S. Ct. 771, 780 n.20 (1994), citing *Michigan Academy* with approval.

Thus, St. Francis submits that *Michigan Academy* is still very much alive. This is particularly so if the Secretary prevails in her *St. Francis I* argument that there is no "amount" in controversy in this case.

The instant case demonstrates that the *St. Francis II* panel erred in declining to follow *Michigan Academy*. This case involves substantial questions regarding the Secretary's good faith implementation of the "statutory commands" set forth in § 1395ww(b)(4)(A) and § 1395ww(b)(1)(A). Under such circumstances, the courts are empowered to grant relief: "We ordinarily presume that Congress intends the executive to obey its statutory commands and, accordingly, that it expects the courts to grant relief when an executive agency violates such a command. That presumption has not been surmounted here." *Michigan Academy*, 476 U.S. at 681.

Petitioner submits that a principal "motive" for the Secretary's actions lies in the TEFRA bonus provisions. Petitioner wishes to use a base year adjustment as the means of obtaining TEFRA bonuses (and as-of-yet unreimbursed costs). By refusing to grant a base year adjustment, the Secretary has precluded Petitioner (and all other providers who happen to experience "distorting" events after their "base year") from participating in the TEFRA incentive program established by Congress.[9]

[9] The failure to grant base year adjustments to hospitals also raises the very real possibility that providers will lose reimbursement payments as well. Without a base year adjustment, providers are forced to file expensive, time-consuming and repetitive cost-year specific appeals. If a provider happens to make a single administrative misstep – *e.g.*, missing a 180-day filing deadline – a whole year's worth of unreimbursed costs might be gone as well (in addition to the lost TEFRA bonuses and the litigation cost associated with filing the redundant appeals).

CONCLUSION

For the foregoing reasons, Petitioner respectfully requests that this Court reverse *St. Francis I* or *St. Francis II*. Petitioner needs a base year adjustment to obtain its TEFRA bonuses in 1986 and to obtain TEFRA bonuses and full reimbursement in the years following 1986, continuing through the present and into the foreseeable future. Moreover, a base year adjustment will function as the sword that will cut the Gordian knot of the post-base-year appeals that Petitioner has been (and will be) forced to file and litigate due to the Secretary's eight-year refusal to grant a base year adjustment.

Given the lengthy history of this "jurisdictional" battle, Petitioner respectfully requests that this Court also consider remanding this case directly to the District Court. *See Bowen v. City of New York*, 476 U.S. 467, 485 (1986) (exhaustion of administrative remedy not required where there was evidence of a "systemwide, unrevealed policy that was inconsistent in critically important ways with established regulations"). *Bowen v. City of New York* applies with even greater force here, given the Secretary's failure to implement two Congressional statutes -- § 1395ww(b)(1)(A) and § 1395ww(b)(4)(A).

Respectfully submitted,

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UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 93-3405

ST. FRANCIS MEDICAL CENTER,

Appellant

v.

DONNA E. SHALALA, Secretary of the
Department of Health and Human Services,
BRUCE C. VLADECK, Administrator,
Health Care Financing Administration; and
JACK MARTIN, Chairman, Provider
Reimbursement Review Board

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

(D.C. Civil No. 89-02452)

Argued: March 2, 1994

Before: SLOVITER, *Chief Judge*, ALITO, *Circuit Judge*, and PARELL, *District Judge**

(Opinion Filed: August 9, 1994)

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*The Honorable Mary Little Parell, United States District Court Judge for the District of New Jersey, sitting by designation.

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OPINION OF THE COURT

ALITO, *Circuit Judge:*

St. Francis Medical Center (SFMC) is a provider of health care services covered under Part A of Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et. seq.*, which is commonly known as the Medicare Act. SFMC appeals from a district court order dismissing its amended complaint for lack of jurisdiction under 28 U.S.C. § 1331. We Affirm.

I.

A. Before 1982, Medicare providers were reimbursed for the "reasonable cost" of covered services. *See Sacred Heart Medical Ctr. v. Sullivan, 958 F.2d 537, 540 (3d Cir. 1992). "Under this regime, hospitals and other health care providers had little incentive to curb operating costs and render services more economically, for the federal governmnent bore the financial burden of increases." Id.* (footnote omitted). "In 1982, Congress determined that the Medicare Program should be modified to provide hospitals with better incentives to render services more economically. Accordingly, in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) Congress amended the [Social Security Act] by imposing a ceiling on the rate of increase of inpatient operating costs recoverable by a hospital." *Id.* (footnote omitted).

"Under TEFRA, a hospital may receive no more than the 'target amount' of per patient costs." *St. Francis Medical Ctr. v. Sullivan,* 962 F.2d 1110, 1111 (3d Cir. 1992) *(St. Francis I).*

> The statute provided: "'target amount' means with respect to a hospital for a particular 12-month cost reporting period—(i) in the case of the first reporting period for which this subsection is in effect, the allowable operating costs of inpatient hospital services . . . recognized . . . for such hospital for the preceding 12-month cost reporting period." [42 U.S.C. §] 1395ww(b)(3)(A). For each reporting period

> subsequent to the initial period, the target amount was increased by a specified percentage. Section 1395ww(b)(3)(A). Under this system, hospitals were obligated to absorb operating costs in excess of their target amounts, but they received bonuses if their operating costs were less than their targeted amounts. Section 1395ww(b)(1)(A).

Sacred Heart Medical Ctr., 958 F.2d at 540.

TEFRA also directed the Secretary to provide for exemptions from, and exceptions or adjustments to, the TEFRA limits (see 42 U.S.C. § 1395ww(b)(3)(A)), and the Secretary has done so. Before 1991, 42 C.F.R. §413.40(g) (1990), which bore the heading "Exceptions," permitted the Health Care Financing Administration (HCFA)[1] to "adjust a hospital's operating costs . . . upward or downward" if the hospital could "show that it incurred unusual costs (in either a cost reporting period subject to the ceiling or the hospital's base period) due to extraordinary circumstances beyond its control" (42 C.F.R. § 413.40(g)(2) (1990)) or if the hospital had experienced a change in its "case mix" (42 C.F.R. § 413.40(g)(3) (1990)). In addition, 42 C.F.R. § 413.40(h), which bore the heading "Adjustments," provided in pertinent part:

> HCFA may adjust the amount of the operating costs considered in establishing cost per case for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, to take into account factors that could result in a significant distortion in the operating costs of inpatient hospital services.

42 C.F.R. § 413.40(h)(1) (1990).

In 1991, these provisions were combined to form what is now 42 C.F.R. § 413.40(g) (1993). Under this provision, the

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[1] The Secretary has delegated considerable administrative responsibility for the Medicare Program to the HCFA. *See Sacred Heart Medical Ctr.*, 958 F.2d at 540 n.4.

HCFA "may adjust the amount of the operating costs considered in establishing the rate-of-increase ceiling for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, under the circumstances specified below." Subsequent provisions state that such adjustments may be granted for essentially the same reasons listed in the previous version of the regulations. *See* 42 C.F.R. § 413.40(g)(2)-(3) (1993).[2]

The Secretary now interprets 42 C.F.R. § 413.40(g) (1993) to mean that a provider may obtain two different types of "base period inpatient operating cost adjustments." Appellees' Br. at 7. According to the Secretary, the first type is "cost year-specific" and may raise a provider's target amount for the purpose of recovering that year's costs but not for the purpose of calculating bonus payments. *Id.* at 7-9. The second type of adjustment, the Secretary explains, results in "a permanent adjustment to the base period inpatient operating costs used to calculate the TEFRA limit," and "any permanent increase in the limit would come into play under the TEFRA bonus provision beginning only with the fiscal year after the one for which any permanent base period relief [is] granted." *Id.* at 8-9. SFMC argues vigorously that the Secretary's recognition of this second type of adjustment represents a recent change in position that was taken for purposes of litigation.

[2] These provisions state:

> (2) *Extraordinary circumstances.* HCFA may make an adjustment to take into account unusual costs (in either a cost reporting period subject to the ceiling or the hospital's base period) due to extraordinary circumstances beyond the hospital's control. These circumstances include, but are not limited to, strikes, fire, earthquakes, floods or similar unusual occurrences with substantial cost effects.
>
> (3) *Comparability of cost reporting periods – (i) Adjustment for distortion.* HCFA may make an adjustment to take into account factors that would result in a significant distortion in the operating costs of inpatient hospital services between the base year and the cost reporting period subject to the limits.

In 1983, Congress largely replaced the TEFRA system with a "prospective payment system" (PPS) (*see Sacred Heart Medical Ctr.*, 958 F.2d at 540), but certain types of hospitals and hospital units were excluded from the PPS. *See* 42 U.S.C. § 1395ww(b), and (d)(1)(A)-(B); 42 C.F.R. §§ 412.20(b), 412.22(b). Among the excluded units were distinct part rehabilitation units. *See* 42 U.S.C. § 1395ww(d)(1)(B); 42 C.F.R. §§ 412.23, 412.30.

B. SFMC operates a general acute-care hospital that includes a rehabilitation unit. For TEFRA purposes, the hospital's base period ended on June 30, 1985. During this period, SFMC's fiscal intermediary concluded that SFMC did not have a distinct part rehabilitation unit under the applicable regulations "since less than 75% of its patients required intensive rehabilitation. The intermediary terminated the provider as a distinct part rehabilitation unit and the Health Care Financ[ing] Administration . . . upheld that decision. To comply with the 75% rule, the Medical Center transferred some of its 'non-qualifying' patients from the rehabilitation unit to its acute care facility. This transfer was completed in the year ending July 30, 1986 ...." *St. Francis I*, 962 F.2d at 1112. Because this transfer was not completed until after the base period ended, SFMC maintains,

> certain "non-qualifying" patients were included on the original 1985 cost report for the Medical Center's rehabilitation unit, but then were transferred out of that unit by 1986. The absence of these "non qualifying" patients from the group of patients treated by the unit in 1986 meant that the Medical Center's average patient costs were higher in 1986 than the estimates of those costs derived from the 1985 base year cost report. In addition, the base year cost report did not include costs associated with a physical expansion project completed in 1986.

Id. at 1113.

SFMC sought relief under 42 C.F.R. § 413.40(g) and (h) for the cost reporting period ending June 30, 1986. Although the intermediary recommended partial relief, the HCFA denied SFMC's requests. The HCFA concluded that SFMC's transfer of nonqualifying patients out of the rehabilitation unit after the base period did not constitute "an extraordinary circumstance beyond the hospital's control" but resulted from a "management decision" to claim the transferred patients as rehabilitation cases in the base year. App. at 24-25. The HCFA also concluded that an adjustment was not warranted by the hospital's building program. *Id.* at 24-25. The HCFA noted that expansion is usually undertaken to accommodate "increased utilization," which in turn tends to "offset any impact on a target rate." *Id.* at 24. However, in SFMC's case, the HCFA observed, "while an expansion program was being implemented, the size of the rehabilitation unit was being decreased." *Id.*

SFMC appealed to the Provider Reimbursement Review Board (PRRB), but the PRRB held that it lacked jurisdiction to hear the appeal because, among other things, SFMC had not satisfied the $10,000 amount-in-controversy requirement in 42 U.S.C. §1395*oo*(f). The PRRB wrote:

> Under Section 1878(a) Title XVIII, Social Security Act, as amended, [42 U.S.C. §1395*oo*(a)], and 42 C.F.R. 405.1835 and 1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary . . . , and the amount in controversy is $10,000, or more, and the request for hearing was filed within 180 days of the date of the final determination .... [T]he amount in controversy for the issues you wish to raise is less than $10,000. Since the above statutory requirement is a prerequisite to a provider's right to a hearing, the Board finds that it does not have jurisdiction over this appeal and hereby dismisses the appeal of the subject year.

App. at 32.[3]

SFMC then filed this action in district court. Asserting that the district court had jurisdiction under 42 U.S.C. §1395*oo*(f), SFMC's complaint alleged that the PRRB had "wrongfully declined jurisdiction" and that the, fiscal intermediary and the HCFA had erred in denying SFMC's requests "to amend and/or reopen its 1985 cost report." App. at 62. The complaint sought a declaration that the intermediary, the HCFA, and the PRRB had acted improperly. *Id.* In addition, the complaint requested that the court order that SFMC be given permission to amend its 1985 cost report; that the intermediary, the HCFA, and the PRRB "recalculate [SFMC's] base year cost per discharge in accordance with its amended cost report"; and that SFMC be awarded the sums due it pursuant to the amended cost report, together with interest thereon" and attorney's fees.*Id* . at 62-63.

The Secretary moved to dismiss the case for lack of jurisdiction, contending that SFMC had not met the $10,000 amount-in-controversy requirement in 42 U.S.C. §1305*oo*(f). The magistrate judge to whom the case had been referred rejected this argument and therefore recommended that this motion be

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[3] While the PRRB denied jurisdiction over SFMC's claims for fiscal year 1985, it exercised jurisdiction over SFMC 's claims for fiscal year 1986. These claims were settled, and SFMC was granted reimbursement for its full inpatient operating costs for fiscal years 1986 through 1988. App. at 36, 46-50; Appellant's Br. at 12. This reimbursement totalled $1,117,355. App. at 37- 38. With respect to bonus payments, the settlement stated:

> The Provider agress that no exception awarded under 42 C.F.R. 413.40(g) by virtue of this settlement or any HCFA decision related to the capital expansion program shall entitle the Provider to any TEFRA incentive payments or other payments in excess of final auditied costs. The parties make no agreement with respect to the appropriateness of any TEFRA incentive payments or other payments in excess of final audited costs should an adjustment be awarded under 42 C.F.R. 413.40(h).

Id. at 39-40. SFMC subsequently dismissed its 1986 PRRB appeal. *Id.* at 259.

denied and that the case be remanded to the PRRB. The magistrate judge did not find that SFMC was seeking to recover $10,000 or more for the cost reporting period at issue, i.e., the period ending on June 30, 1986. Instead, the magistrate judge concluded:

> The PRRB attempts to isolate each year involved to determine whether it meets the $10,000.00 requirement, but the claim requires the board to look at the years 1985 through 1988 as a whole because they are inextricably connected, since the base year is the foundation for a continuing inaccuracy in plaintiff's reimbursements from Medicare. Plaintiff easily meets the $10,000.00 jurisdictional amount as defined in 42 C.F.R. Section 405.1839(a)(2) for the years 1986, 1987 and 1988, for which the TEFRA rate of increase limits are determined by the 1985 cost report. It is unreasonable and inefficient to require plaintiff to file annually for an exception to the TEFRA limits when a recalculation of the base year cost report, if proven to be inaccurate, would obviate the problem.

App. at 71-72. The district court accepted the magistrate judge's recommendation.

On appeal, a divided panel of our court reversed and held that SFMC had not satisfied the $10,000 amount-in-controversy requirement. Noting that "[t]he 'amount in controversy' is defined by [42 U.S.C. § 1395*oo*(a)(l)(A)(i)] as 'the amount of total program reimbursement due to the provider for the items and services furnished to individuals for which payment may be made . . . *for the period covered by such report*,'" the panel held that a single provider may not "aggregate claims over several cost reports in order to satisfy the amount in controversy requirement of § 1395*oo*(a)." *St. Francis I,* 962 F.2d at 1114, 1115 (emphasis supplied in *St. Francis I*). However, in response to SFMC's argument that the district court had jurisdiction under 28 U.S.C. § 1331, the panel remanded the case to the district

court so that SFMC could petition for leave to amend its complaint to assert jurisdiction under that provision. 962 F.2d at 1117. In doing so, however, the panel made clear that it was not deciding whether SFMC's claims could "properly be asserted under this jurisdictional provision." *Id.* at 1117 n.10.

On remand, SFMC was granted leave to file an amended two-count complaint that asserted jurisdiction under 28 U.S.C. § 1331. Count I of the amended complaint alleged:

> The methodology, or lack of methodology, utilized by HCFA to deny to St. Francis Medical Center a base year adjustment (to achieve comparability between cost reporting periods) has resulted in HCFA's imposition of improper and unreasonable reimbursement ceilings (TEFRA Ceilings) upon the Medical Center's rehabilitation unit.

App. at 212. Count II alleged that SFMC's equal protection rights had been violated because it had been treated differently from providers "whose post-base year costs for post-base year cost reporting periods . . . are undistorted." *Id.* at 213. Counts I and II of the amended complaint sought essentially the same relief as SFMC's prior complaint. *Id.* at 213 - 15.

The defendants moved to dismiss, and the magistrate judge recommended that the motion be granted on the ground that 42 U.S.C. § 405(h) precluded the exercise of jurisdiction under 28 U.S.C. § 1331. The district court agreed and dismissed the amended complaint. This appeal followed.

II.

Under the Medicare Act, 42 U.S.C. § 1395*oo*(f)(1), a provider has "the right to obtain judicial review of any final decision" of the PRRB by means of a civil action filed in district court. In *St. Francis I*, however, our court held that SFMC could not obtain judicial review under this provision because it had not satisfied the $10,000 amount-in-controversy requirement of 42 U.S.C. § 1395*oo*(a). SFMC thus turned to 28 U.S.C. § 1331 as an alternative avenue for obtaining review, but SFMC's reliance on this provision raises other jurisdictional problems.

The Medicare Act, 42 U.S.C. § 1395ii, incorporates 42 U.S.C. § 405(b), which provides in relevant part:

> The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. *No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.*

42 U.S.C. §405(h) (emphasis added). Therefore, if SFMC's amended complaint seeks "to recover on [a] claim arising under [the Medicare Act]," this provision deprives the district court of jurisdiction under 28 U.S.C. § 1331.

As the District of Columbia Circuit has noted, resolution of this jurisdictional issue requires us to consider two lines of Supreme Court precedent: the "*Salfi-Ringer* line" and the "*Erika-Michigan Academy* line." *See National Kidney Patients Ass'n v. Sullivan*, 958 F.2d 1127, 1130 (D.C. Cir. 1992), *cert. denied*, 113 S. Ct. 966 (1993). We will consider each of these lines separately.

A. If the "*Salfi-Ringer* line" controls, the decision of the district court dismissing SFMC's complaint was clearly correct.

In *Weinberger v. Salfi*, 422 U.S. 749 (1975), the Court considered an action brought on behalf of a class of persons who had been denied Social Security benefits pursuant to a provision of the Social Security Act that permitted a widow or stepchild to obtain benefits only if that claimant had become the wife or stepchild of the deceased at least nine months before his death. A three judge court held that this statutory requirement was unconstitutional, but the Supreme Court concluded that 42 U.S.C. §405(h) deprived the lower court of jurisdiction to entertain the suit under 28 U.S.C. § 1331. The Court rejected the proposition that section 405(h) merely requires exhaustion of administrative remedies (422 U.S. at 757), as well as the argument that the plaintiffs' claims arose under the Constitution rather than the Social Security Act. *Id.* at 760. The Court wrote:

> It would, of course, be fruitless to contend that appellees' claim is one which does not arise under the Constitution, since their constitutional arguments are critical to their complaint. But it is just as fruitless to argue that this action does not also arise under the Social Security Act. For not only is it Social Security benefits which appellees seek to recover, but it is the Social Security Act which provides both the standing and the substantive basis for the presentation of their constitutional contentions. Appellees sought, and the District Court granted, a judgment directing the Secretary to pay Social Security benefits. To contend that such an action does not arise under the Act whose benefits are sought is to ignore both the language and the substance of the complaint and judgment. This being so, the third sentence of § 405(h) precludes resort to federal-question jurisdiction for the adjudication of appellees' constitutional contentions.

*Id.*at 760-61. The Court thus held that individuals wishing to challenge the duration-of-relationship requirement were re-

quired to proceed under 42 U.S.C. §405(g) rather than under 28 U.S.C. § 1331. *See* 422 U.S. at 763-67.

In *Heckler v. Ringer,* 466 U.S. 602 (1984), the plaintiffs were individuals who wanted Medicare to pay Part A benefits[4] for a surgical procedure known as bilateral carotid body resection (BCBR). The Secretary through the HCFA adopted a policy that "no payment [was] to be made for Medicare claims arising out of the BCBR surgical procedure when performed to relieve respiratory distress." *Id.* at 607; see also *id.* at 608. Asserting jurisdiction based in part on 28 U.S.C. § 1331, the plaintiffs filed suit, contending that the Secretary's policy violated "constitutional due process and numerous statutory provisions." 466 U.S. at 610. The Supreme Court held however, that juristiction under 28 U.S.C. § 1331 was not available, and the Court specifically rejected the distinction that the court of appeals had drawn between substantive and procedural claims. 466 U.S. at 614-15. "[T]o be true to the language of the statute," the Court wrote,

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[4] As we recently explained:

> Medicare coverage is primarily divided into two parts. Part A covers all inpatient hospital expenses through an insurance plan. *See* 42 U.S.C. §§ 1395c to 1395i-4. All Medicare-eligible patients receive this benefit. . . .
>
> Part B covers certain physician services, hospital outpatient services, and other health services not covered under Part A. *See* 42 U.S.C. §§ 1395j to 1395w-4(j). Part B coverage is not freely or automatically available to all Medicare-eligible patients. To obtain this coverage, Medicare-eligible patients must first enroll in the Part B insurance program by paying insurance premiums ("Part B insurance premiums"). *See* § 1395*o*-1395s. Once this is done, the federal government pays 80% of the "reasonable costs" for outpatient hospital services and 80% of the "reasonable charges" for physician services rendered to the insured. §1305*l*. The Part B patients themselves must pay the remaining 20% of the charges for the reasonable outpatient hospital services and physician services copayments or coinsurance), as well as an annual deductible. *Id.*; § 1395cc(a)(2)(A).

Pennsylvania Medical Soc'y v. Snider, No. 93-7775 (3d Cir. July 22, 1994), slip op. at 4.

"the inquiry in determining whether §405(h) bars federal-question jurisdiction must be whether the claim 'arises under' the Act, not whether it lends itself to a 'substantive' rather than a 'procedural' label." 466 U.S. at 615.

Turning to the case at hand, the Court concluded that the plaintiffs' "challenge to the Secretary's BCBR payment policy '[arose] under' the Medicare Act." *Id.* at 615 (brackets added). The Court found it inconsequential that the plaintiffs "sought only declaratory and injunctive relief and not an actual award of benefits as well" because "[f]ollowing the declaration which respondents seek from the Secretary — that BCBR surgery is a covered service — only essentially ministerial details will remain before respondents would receive reimbursements." *Id.* Instead of invoking 28 U.S.C. § 1331 or the mandamus statute, the Court held, claimants wishing to challenge the Secretary's BCBR policy were required to proceed under 42 U.S.C. §405(g). 466 U.S. at 617.

If *Salfi* and *Ringer* are controlling in this case, there can be little doubt that the district court lacked general federal-question jurisdiction. The Medicare Act provides "both the standing and substantive basis" for SFMC's claims. *Salfi,* 422 U.S. at 761. Moreover, SFMC "sought . . . a judgment directing the Secretary to pay [Medicare] benefits." *Id.* Accordingly, under these precedents, SFMC's claim "arises under" the Medicare Act for purposes of section 405(h). *See Ringer,* 466 U.S. at 615; *Salfi,* 422 U.S. at 760-61; *In re Univ. Medical Ctr.*, 973 F.2d 1065, 1073 (3d Cir. 1992); *Abington Memorial Hosp. v. Heckler,* 750 F.2d 242, 244 (3d Cir. 1984), *cert. denied,* 474 U.S. 863 (1985). Under these precedents, it makes no difference that SFMC asserted constitutional and procedural claims. *See Ringer*, 466 U.S. at 615; *Salfi*, 422 U.S. 761.

B. SFMC makes little attempt to distinguish *Salfi* or *Ringer.* Instead, SFMC relies on the Supreme Court's later decision in *Bowen v. Michigan Academy of Family Physicians,*

476 U.S. 667(1986), which concerned a regulation governing payments under Part B of the Medicare program. This regulation permitted carriers to establish separate prevailing charges for specialists and nonspecialists performing the same services. An association of physicians and several individual doctors challenged the regulation on constitutional and statutory grounds, but the Secretary contended that Congress ha[d] forbidden judicial review of all questions affecting the amount of benefits payable under Part B of the Medicare program." *Id.* at 669. In making this argument, the Secretary relied on *United States v. Erika, Inc.*, 456 U.S. 201 (1982), in which the Court had held that the Medicare Act precluded any judicial review of a carrier's decision concerning the amount awarded on a Part B claim. The Secretary also argued that 42 U.S.C. § 405(h) bolstered this conclusion.

The Supreme Court, however, disagreed. Beginning with "the strong presumption that Congress intends judicial review of administrative action" (476 U.S. at 670), the Court held that neither the Medicare Act nor 42 U.S.C. §405(h) demonstrated with the requisite clarity that Congress intended to preclude all judicial review of "any action taken under Part B of the Medicare program." 476 U.S. at 673. The Court held that the portion of the Medicare Act governing review of Part B determinations, as interpreted in *Erika,* "simply does not speak to challenges mounted against the *method* by which such amounts are to be determined rather than the *determinations* themselves." *Id.* at 675 (emphasis in original). The Court then concluded that, whereas a carrier's decision concerning the amount of a Part B claim was not subject to any form of judicial review, those Part B matters that a carrier cannot decide— "including challenges to the validity of the Secretary's instructions and regulations" — are not insulated from review under the Medicare Act. *Id.*at 678.

As for 42 U.S.C. § 405(h), the Court wrote that it would not "indulge the Government's assumption that Congress contemplated review by carriers of 'trivial' monetary claims . . . but intended no review at all of substantial statutory and constitutional challenges to the Secretary's administration of Part B of the Medicare program." 476 U.S. at 680 (footnote omitted). The Court found insufficient evidence to show that Congress meant to take this "extreme position." *Id.*

In subsequent cases involving Part B of the Medicare program, we explained that "*Erika* and *Michigan Academy* define the ends of a continuum." *American Ambulance Serv. v. Sullivan*, 911 F.2d 901, 905 (3d Cir. 1990); *see also Medical Fund-Phila. Geriatric Ctr. v. Heckler*, 804 F.2d 33, 38 (3d Cir. 1986). We elaborated:

> At one end are disputes over amount computations at issue in a particular case. At the other are disputes arising from the Secretary's rules, regulations and instructions which are applied by the Hearing Officer. A Hearing Officer is not at liberty to disregard these rules.... "[M]atters which Congress did *not* delegate to private carriers, such as challenges to the validity of the Secretary's instructions and regulations, cognizable in courts of law." *Michigan Academy*, 476 U.S. at 680, 106 S. Ct. at 2140-41 (emphasis in original).

American Ambulance Serv., 911 F.2d at 905.

Contrary to SFMC's argument, we do not believe that *Michigan Academy* supports its reliance on general federal-question jurisdiction in this case. *Michigan Academy* concerned the availability of general federal-question jurisdiction to review the validity of a Part B regulation. Under Part B, a carrier cannot review the legality of such a regulation *(see Michigan Academy,* 476 U.S. 675-76, 680) and, as *Erika* held, a carrier's determination of the amount of a Part B payment is not reviewable. Thus, if general federal-questton jurisdiction had not been available in

Michigan Academy, the plaintiffs in that case would have had no avenue for challenging the validity of the regulation under which their payments were calculated.

By contrast, the Medicare Act provides avenues by which a provider seeking Part A payments may contest both the amount of its payments and the methods by which those payments are calculated. If the provider seeks review of a reimbursement determination and does not wish to challenge a provision of the Act or regulations, it may, upon compliance with the jurisdictional requirements imposed by statute, take an appeal to the PRRB *(see* 42 U.S.C. § 1395*oo*(f)(1)). Alternatively, if the provider wishes to challenge a provision of the Act or a regulation, it may seek a determination by the PRRB that the Board lacks the authority to decide the question (*see* 42 U.S.C. § 1395*oo*(f)(1)) and then obtain judicial review. *See Good Samaritan Hosp. v. Shalala,* 113 S. Ct. 2151, 2156 (1993); *Bethesda Hosp. Ass'n v. Bowen,* 485 U.S. 399, 401-02 (1988).

Since a provider seeking Part A payments has these avenues of review available under the Medicare Act, the presumption that Congress did not intend to foreclose judicial review, which was central to the decision in *Michigan Academy*, is inapplicable. And in the absence of that presumption, we read 42 U.S.C. § 405(h), as incorporated into the Medicare Act and as interpreted in *Salfi* and *Ringer*, to mean that SFMC may not assert its claim under 28 U.S.C. § 1331.

In *Westchester Management Corp. v. United States HHS*, 948 F.2d 279 (6th Cir. 1991), *cert. denied,* 112 S. Ct. 1936 (1992), the Sixth Circuit considered a case quite similar to the one before us. Noting that 42 U.S.C. § 1395*oo*(f)(1) provided "an avenue of judicial review for the type of challenge that [the provider] assert[ed]," the court stated that "the *Michigan Academy* exception applies only when there is no other avenue of judicial review." 948 F.2d at 282. The court continued:

> Congress has expressly provided for judicial review of the type of claim that Westchester Management asserts, when the claim exceeds the $10,000 amount-in-controversy requirement. Congress created a special procedure by which a provider that, unlike Westchester Management, is entitled to a Board hearing may demand that the Board determine whether it has authority to pass on a relevant legal question, such as the validity of an instruction of the Secretary. If it determines that it lacks authority, the provider may proceed directly to court for judicial review of its legal challenge. *See* 42 U.S.C. § 1395*oo*(f)(1). If we were to accept Westchester Management's construction of *Michigan Academy* that there is always jurisdiction under 28 U.S.C. §§ 1331 and 1346 for challenges to instructions, rules, and regulations, but not for amount determinations—this special procedure, created by 42 U.S.C. § 1395*oo*(f)(1), would become superfluous.
>
> The better construction requires that Westchester Management pursue the exclusive jurisdictional grant within the Medicare Act. Its claim that it has no avenue of judicial review is meritless; 42 U.S.C. §1395*oo*(f)(1) provides an avenue of judicial review for the sort of challenge to the validity of the Secretary's instructions that it raises. Westchester Manageement is, however, denied access to that avenue because it is unable to meet the amount-in-controversy requirement. There is no contention that Congress lacks the power to limit jurisdiction by prescribing minimum amount-in-controversy requirements.

Id. at 282-83; *see also Colonial Penn Ins. Co. v. Heckler*, 721 F.2d 431, 436 (3d Cir. 1983); *Frankford Hosp. v. Davis*, 647 F. Supp. 1443, 1446-47 (E.D. Pa. 1986); *Mount Sinai Medical Ctr. v. Sullivan*, Medicare & Medicaid Guide (CCH) ¶39,103 (D.D.C. Nov. 30, 1990). We find this analysis persuasive.

We note, moreover, that administrative remedies are now available for providers who believe that their base period operating costs are too low. Beginning in 1990, a provider may request a new base period. *See* 42 U.S.C. §§ 1395ww(b)(4)(A)-(B) (Supp. 1993); 42 C.F.R. § 413.40(i). As previously noted (see pages 4-5, supra, a provider may also request a permanent base-period cost adjustment under 42 C.F.R. § 413.40(g). A denial of either of these requests may be appealed to the PRRB and is thereafter subject to judicial review under 42 U.S.C. § 1395*oo*(f)(1).

SFMC contends that these procedures are inadequate in its case. SFMC correctly notes that the granting of a new base period beginning in 1990 pursuant to 42 C.F.R. § 413.40(i) would not permit it to recover the bonus payments that it believes it should have received prior to that date. As for a permanent base-period cost adjustment, SFMC argues that the Secretary has only recently recognized the availability of such relief. Indeed, SFMC charges that the Secretary previously took the position that no such relief was available and that the Secretary's current interpretation of the relevant regulations is simply a "convenient litigating position." The Secretary disputes these charges. But whether or not SFMC's charges are justified, we do not think they have a bearing on the availability of jurisdiction under 28 U.S.C. § 1331, for "Subject matter jurisdiction can never be created by estoppel." *Rubin v. Buckman*, 727 F.2d 71, 72 (3d Cir. 1984); *see Insurance Corp. of Ireland v. Compagnie des Bauxites de Guinee*, 456 U.S. 694, 702 (1982).

SFMC also argues that, even now, while the Secretary acknowledges that a permanent base-period adjustment would apply in determining a provider's entitlement to TEFRA bonus payments in future years, the Secretary takes the position that such an adjustment would not apply in detemining a provider's entitlement to bonus payments in the year in which permanent

adjustment is granted. In other words, SFMC contends that the administrative procedure may cause a provider to lose a year of incentive payments.

This argument does not persuade us that such a provider must be permitted to sue to recover these bonus payments under 28 U.S.C. § 1331. If such a provider has a substantive entitlement to these bonus payments under the Medicare Act, it is by no means clear to us that the provider could not obtain those payments in an action under 42 U.S.C. § 1395*oo*(f)(1), irrespective of the regulations or the Secretary's interpretation of them. On the other hand, if such a provider has no such entitlement, then obviously the Secretary's position causes the provider no harm. But in any event, even if the Secretary's position may by some means cause the provider to lose a year of bonus payments, that possibility is insufficient to persuade us that jurisdiction under 28 U.S.C. § 1331 must be recognized.

We have considered all of SFMC's remaining arguments and we find them to lack merit. Accordingly, we will affirm the decision of the district court dismissing SFMC's complaint.

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

Nos. 91-3406 and 91-3429

ST. FRANCIS MEDICAL CENTER

v.

LOUIS W. SULLIVAN, M.D., Secretary of the Department of Health and Human Services, and LOUIS B. HAYES, Acting Administrator, Health Care Financing Administration, and ELISE D. SMITH, Chairman Provider Reimbursement Review Board,

UNITED STATES OF AMERICA,
Appellant in No. 91-3406

LOUIS W. SULLIVAN, M.D., Secretary of the Department of Health and Human Services, and LOUIS B. HAYES, Acting Administrator, Health Care Financing Administration, and ELISE D. SMITH, Chairman Provider Reimbursement Review Board,
Appellants in No. 91-3429

APPEALS FROM THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

Filed April 24, 1992
D.C. Civil No. 89-02452

Argued December 10, 1991
BEFORE: SCIRICA, ALITO, and SEITZ
Circuit Judges.
Filed April 24, 1992

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OPINION OF THE COURT

SEITZ, *Circuit Judge.*

This is an appeal by the Secretary of the Department of Health and Human Services, et al. from an order of the district court. That order overturned the Provider Reimbursement Review Board's ("Board") refusal on Jurisdictional grounds to grant the request of the plaintiff, St. Francis Medical Center ("Medical Center"), for a hearing. The dispute arises over reimbursement allegedly due from the Secretary to a provider of hospital services under the Medicare statute, 42 U.S.C. § 1395 *et. seq.* The narrow issue presented is whether the provider met the requirement in the statute, 42 U.S.C. § 1395oo(a) (1984) that limits hearing by the Board to claims involving amounts of $10,000 or more. The Medical Center asserts, alternatively, that federal question jurisdiction is available to entertain this provider's claims pursuant to 28 U.S.C. § 1331 (1980).

I. FACTUAL BACKGROUND AND PROCEDURAL HISTORY

A. STATUTORY AND REGULATORY BACKGROUND

The Medical Center is a "provider" of health care services covered under Part A of the Medicare statute, 42 U.S.C. § 1395 *et. seq.* Payments under Part A are made directly to eligible providers under the reimbursement scheme enacted in 1982, the Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA"), Pub. L. No. 97-248 (codified, as amended, at 42 U.S.C. § 1395ww (b) (1988).

Under TEFRA, a hospital may receive no more than the "target amount" of per patient costs that is calculated according to the hospital's actual cost of service in the base year. The base year cost reporting period is the year prior to the first year when

the TEFRA reimbursement scheme becomes effective. *See* 42 U.S.C. § 1395ww(b)(3)(A) (1988). In that year and in subsequent years, a hospital's Medicare reimbursement is limited to "the allowable operating costs of inpatient hospital services" incurred in the base year. § 1395ww(b)(3)(E). The TEFRA target amount determines the maximum amount of reimbursement that the hospital can receive per patient in subsequent years. If the hospital renders care at a cost below its TEFRA target amount, it receives an "incentive payment" as a reward for its efficiency. The incentive payment is equal to fifty percent of the difference between the hospital's actual costs and its target amount of maximum per patient reimbursement. 42 U.S.C. § 1395ww(b).

The jurisdictional dispute in this case arose from the Medical Center's claim as a provider seeking to adjust the cost report for the base year 1985, in order to qualify for an incentive payment. The Medical Center's base year adjustment request was denied by the intermediary and it sought a hearing to review that determination before the Board. Such a hearing may be obtained if the jurisdictional requirements of § 1395oo(a) are met. That section provides:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by [the Board] ... if –
>
> (1) such provider –
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary ... as to the amount of total program reimbursement *due the provider for the items and sevices furnished to individuals for which payment may be made under this subchapter for the period covered by such report,* ...
>
> * * * *

> (2) *the amount in controversy is $10,000 or more, and*
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's [or Secretary's] final determination ....

(emphasis added)

The Board denied the Medical Center's request on the ground that it lacked jurisdiction under § 1395oo(a) because the amount in controversy requirement was not met. Ultimately, the Board's decision becomes final unless the Secretary, on his own motion, within 60 days, reverses, affirms or modifies the Board's decision. *See* 42 U.S.C. § 1395oo(f)(1) (1984). In this case, the Secretary did not alter the Board's decision and it became final. The Medical Center then filed this action in the district court, *inter alia*, under § 1395oo(f)(1). The district court reversed the Board's ruling and the Secretary now appeals.

B. ADMINISTRATIVE AND JUDICIAL PROCEEDINGS

The Medical Center sought reimbursement under TEFRA as a "distinct part rehabilitation unit," as defined by the TEFRA regulations.[1] The intermediary, Blue Shield of Western Pennsylvania, concluded that the Medical Center was not a "rehabilitation unit" under the regulations since less than 75% of its patients required intensive rehabilitation. The intermediary terminated the provider as a distinct part rehabilitation unit and the Health Care Finance Administration (hereinafter "HCFA") upheld that decision. To comply with the 75% rule, the Medical Center transferred some of its "non-qualifying" patients from the rehabilitation unit to its acute care facility. This transfer was completed in the year ending July 30, 1986, beyond the base year.

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[1] 42 C.F.R. § 405.471(c)(2)(ii) [redesignated in 1985 as 42 C.F.R. §412.29(a)] (hereinafter "the 75 percent rule.") *See also* 42 C.F.R. § 4123.29(a). *See generally, Delaware County Memorial Hospital v. Bowen*, 871 F.2d 10 (3d Cir. 1989).

The non-qualifying patients in the rehabilitation unit in 1985 were nevertheless included in the Medical Center's 1985 base year cost report. Since the Medical Center's TEFRA target amount was set according to that base year, the Medical Center's 1985 cost report substantially underestimated its actual costs in 1986. The underestimate arose from the fact that certain "non-qualifying" patients were included on the original 1985 cost report for the Medical Center's rehabilitation unit, but then were transferred out of that unit by 1986. The absence of these "non-qualifying" patients from the group of patients treated by the unit in 1986 meant that the Medical Center's average patient costs were higher in 1986 than the estimates of those costs derived from the 1985 base year cost report. In addition, the base year cost report did not include costs associated with a physical expansion project completed in 1986. The difference between 1985 and 1986 average patient costs for the patients receiving service in 1986 was an amount in excess of $700,000.

To obtain relief from this distortion, the Medical Center submitted an amended base year cost report pursuant to 42 C.F.R. § 413.40(h) (1988). The intermediary denied this initial request to adjust or amend the 1985 cost report and issued a final Notice of Program Reimbursement ("NPR".) The Medical Center then filed a request for a base year adjustment, pursuant to 42 C.F.R. § 413.40(h) and, in the alternative, requested an "exception" to its 1986 TEFRA target amount, pursuant to 42 U.S.C. § 1395ww(b)(4)(A) and 42 C.F.R. § 413.40(g) (1988).[2]

The intermediary rejected the base year adjustment request and, instead, recommended to the HCFA that the Medical Center be granted an exception to its 1986 TEFRA target amount. In reviewing that decision, the HCFA denied the base year cost adjustment claim, as well as the request for an exception to the

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[2] Later, in support of this base year adjustment request, the Medical Center submitted a further revision to the cost report on April 13, 1988.

1986 TEFRA target amount. The Medical Center sought a hearing before the Board on that decision.

The Board ruled that it lacked jurisdiction over the Medical Center's request for a base year cost adjustment. It found that the $10,000 amount in controversy requirement of § 1395(a) was not met.

The Medical Center filed this action in the district court against the Secretary and the court exercised jurisdiction pursuant to 42 U.S.C. § 1395oo(f). *See McKeesport Hospital v. Heckler,* 612 F. Supp. 279, 282 (W.D.Pa. 1985). Pursuant to a designation from the district court, the magistrate heard the case and issued a Report and Recommendation that the Secretary's motion to dismiss be denied and the case be remanded to the Board for review on the merits. The district court adopted the report and recommendation of the magistrate as its own and entered an order denying the Secretary's motion to dismiss and remanding the matter to the Board for determination of the merits.[3] This appeal by the Secretary followed.

II. JURISDICTION

Although the parties do not challenge our jurisdiction, we have an independent obligation to decide whether 28 U.S.C. § 1291 (1982) provides a jurisdictional basis for this appeal.

The Medical Center filed its complaint in the district court pursuant to § 1395oo(f)(1).[4] That court reversed the Board's jurisdictional ruling and remanded the matter to the Board. It is true that "remands to administrative agencies are not ordinarily

[3] Although the district court's order itself does not explicitly implement its ruling as to the jurisdiction of the Board, the parties have treated it as doing so. Respecting substance over form we conclude that the order did amount to a final order.

[4] "Providers shall have the right to obtain judicial review of any final decision of the [Board], or of any reversal, affirmance, or modification by the Secretary by a civil action commenced within 60 days of the date on which notice of any final decision by the [Board] or of any reversal, affirmance or modification by the Secretary is received."

appealable," *Finkelstein v. Bowen*, 869 F.2d 215, 217 (3d Cir. 1989), *rev'd sub. nom Sullivan v. Finkelstein*, 110 S.Ct. 2658 (1990). However, there are exceptions to this rule. For example, the Medicare statute confers jurisdiction on the district court over any "civil action" filed there by a Medicare provider pursuant to 42 U.S.C. § 1395(f). The Supreme Court in *Finkelstein* construed a similar judicial review provision in the Social Security Act, 42 U.S.C. § 405(g). In reviewing the district court's remand order, the Court held that it was appealable because the "[t]he use of the term "civil action" [in § 1395(f)] suggests that each final decision of the Secretary will be reviewable by a separate piece of litigation." *Id.*, 110 S.Ct. at 2663.

As in *Finkelstein*, if this appeal is dismissed and the Secretary's final decision awards relief to the Medical Center, we have grave doubts whether the Secretary could obtain any later review of the jurisdictional issue presented in this appeal. *Id.*, 110 S.Ct. at 2664.[5] Based on the reasoning of *Finkelstein*, we conclude that the district court's order, which terminated proceedings in the district court, is a "final decision" subject to immediate appeal for purposes of 28 U.S.C. § 1291.[6]

III. DISCUSSION

We now turn to the primary issue in this case, namely, did the district court err in concluding that the Board had subject matter jurisdiction to grant a hearing on the Medical Center's reimbursement claims, despite the $10,000 amount in contro-

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[5] Thus, the posture of this appeal differs from a case where the provider has appealed a remand by the district court to obtain broader relief. *Finkelstein*, 110 S.Ct. at 2663 n.3.

[6] Moreover, this result is supported by decisions in other circuits prior to *Finkelstein*. *St. Mary's Hospital Medical Center v. Heckler*, 753 F.2d 1362 (7th Cir.), *cert. denied*, 472 U.S. 1028 (1985); *Edgewater Hospital, Inc. v. Bowen*, 857 F.2d 1123, 1127-9 (7th Cir. 1988); *Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d 1435, 1443 n.12 (11th Cir. 1987), *cert. denied*,108 S.Ct. 1573 (1988).

versy requirement found in 42 U.S.C. § 1395oo(a). Since this presents a legal issue, our standard of review is plenary.

In denying jurisdiction, the Board stated simply that "the amount in controversy for the issues you wish to raise is less than $10,000." In reversing that finding, the district court decided that the statutory jurisdictional amount requirement was easily met. It reasoned that a cost adjustment in the 1985 base year would have automatically resulted in an increase in the amounts due the provider in the years 1986, 1987 and 1988 and that these amounts would be well in excess of $10,000.

On appeal, the Medical Center contends that the district court correctly decided that it met the Board's jurisdictional requirement. In so contending, the Medical Center interprets §1395oo(a) to require the Board to grant a hearing whenever the claim involves at least $10,000 in additional reimbursement, whether or not that reimbursement is due in the year of the cost report in dispute. Under this view, the amount in controversy requirement can be met by aggregating amounts of reimbursement due over cost reports covering several years. The Secretary argues that this "amount in controversy" requirement may not be met by including the reimbursement due to the Medical Center in the 1986-88 period because the dispute here relates only to the 1985 cost report.

As we read § 1395oo(a), it does not permit a single provider to aggregate claims over several cost reports in order to satisfy the amount in controversy requirement of § 1395oo(a) with respect to the base year. Rather, § 1395oo(a) limits a provider's request for a Board hearing to claims that could result in reimbursement of $10,000 or more due the provider under the cost report in dispute. Our view of the statute is based primarily on the language of 42 U.S.C. § 1395oo(a).

The language of 42 U.S.C. § 1395oo(a)(2) clearly provides that a single provider's request for a Board hearing on the denial of a reimbursement claim must involve $10,000 or more with

respect to a "required cost report," which must be filed yearly. Further, the language of § 1395oo(a)(1)(A)(i) cannot be reconciled with the Medical Center's argument that the "amount in controversy" equals the difference between the base year costs that the Medical Center claims and the lower costs calculated by the HCFA. The "amount in controversy" is defined by this provision as "the amount of total program reimbursement due to the provider for the items and services furnished to individuals for which payment may be made ... *for the period covered by such report.*" § 1395oo(a)(1)(A)(i) (emphasis added). Moreover, the "amount" that must be "in controversy," according to the statute, relates to a dispute regarding "payment" of reimbursement "as the Secretary may require." § 1395oo(a).

Nowhere in the statute is it stated that a single provider may aggregate amounts in controversy raised by several cost reports to meet the amount in controversy requirement to obtain a hearing before the Board. The lack of any mention of such aggregation in §1395oo(a) demonstrates that a single provider's request must be limited to claims for reimbursement arising in a single cost report. If Congress had intended to authorize such aggregation of claims from several cost reports in a single provider appeal, it is reasonable to assume that it would have so provided.

Notwithstanding the language of the single provider hearing provision, the Medical Center suggests that we must permit it to aggregate its claims over several cost reports by analogy to the group provider hearing provision, 42 U.S.C. § 1395oo(b). The group provision authorizes the filing of a request for a Board hearing where several cost reports of members of the group involve an "amount in controversy" that "in the aggregate" is $50,000 or more.

The analogy that the Medical Center attempts to draw between this case and a group provider request fails. Congress intended to permit groups of providers to avoid the $10,000

amount in controversy requirement by aggregating their claims. They may do so, however, only when their claims present the Board with a common question of law and fact. *See generally Good Samaritan Hospital v. Sullivan,* No. CV88-L-523 (D. Neb. 2/16/90); Medicare & Medicaid Guide (CCH), ¶38,400 (1990) (multiple claims may be aggregated where they present issues of law and fact common to the group), *rev'd in part, aff'd in part on other grounds,* 952 F.2d 1017 (8th Cir. 1991). Group provider requests are subject to a less stringent amount in controversy requirement because Congress made a policy decision to treat aggregated smaller claims less stringently than single providers' claims. *Cleveland Memorial Hospital, Inc. v. Califano,* 594 F.2d 993, 996 (4th Cir. 1979).

Thus, we cannot agree with the Medical Center's argument that decisions interpreting the group provider request provision are controlling and require the Board to find that it had jurisdiction over this single provider's application. The Medical Center asserts that *Cleveland Memorial Hospital, Inc.,* 594 F.2d at 995 n.4 and *White Memorial Medical Center v. Schweiker,* 640 F.2d 1126 (9th Cir. 1981) support its position. These decisions are inapposite because they interpreted the language of the group provider hearing request provision, § 1395oo(b), according to its plain language. They did not express a view whether §1395oo(a) permits single providers to aggregate claims over several cost report years to meet the amount in controversy requirement.

Even if the language of 42 U.S.C. § 1395oo(a) and §1395oo(f) do not clearly deny the Board jurisdiction to entertain this provider's claims, we believe the regulations support the Secretary's position. First, the Secretary's implementing regulations do not permit the aggregation of costs over several cost reports to meet the amount in controversy requirement. They authorize a provider to request a hearing when it seeks reimbursement of $10,000 or more based on a single cost report

in dispute. *See* 42 C.F.R. § 405.1835(a); 42 C.F.R. § 1801(a)(1) (defining an "intermediary's determination" as "a determination of total reimbursement due ... for the period covered by the cost report.") The Secretary has consistently followed this regulation in refusing to aggregate the amounts in dispute from several costs reports submitted by a single provider in determining if the $10,000 amount in controversy threshold of § 1395oo(a) has been met. *See Bradner Village v. Blue Cross & Blue Shield Ass'n/Blue Cross of Indiana,* Medicare & Medicaid Guide (CCH), ¶38,428 at 22,412 (HCFA Administrator Decision, March 11, 1990); *Home Call, Inc. v. Blue Cross & Blue Shield Association,* Medicare & Medicaid Guide (CCH), ¶36,261 at 13,862 (HCFA Administrator Decision, February 6, 1987).

Second, the regulation that defines how the amount in controversy is to be calculated excludes non-reimbursable costs such as costs incurred in a subsequent year. 42 C.F.R. § 405.1839(a)(2) provides that the $10,000 amount in controversy requirement will be calculated, for provider reimbursement under TEFRA, according to the following formula: "by deducting the adjusted total reimbursable program costs due to the provider on a reasonable cost basis from the total *reimbursable* costs claimed by the provider." (emphasis added)

The Medical Center did not meet this definition of amount in controversy because it did not claim reimbursable costs in excess of $10,000 that were actually incurred in 1985 but not included by it in the base year cost report. In other words, the Medical Center did not show that, after subtracting the amount of reimbursement determined by the intermediary on the NPR from the reimbursable costs it claims were incurred in 1985, the difference is an amount of $10,000 or more.[7]

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[7] The Secretary contends that the amount in controversy requirement of §1395oo(a) requires the provider to request relief that will result in the payment from the Medicare program of a positive amount of $10,000 or more for the cost report in dispute. Given our resolution of this issue, we need not address the merits of the Secretary's definition of amount in controversy in its brief on appeal.

Thus, even if the statutory provision is considered to be unclear and we are thereby able to resort to these regulations for enlightenment, we conclude that they would compel the same conclusion we have reached in interpreting the language of the statute. Since the Social Security Act expressly grants the Secretary rulemaking power, "'our review is limited to determining whether the regulations promulgated exceeded the Secretary's statutory authority and whether they are arbitrary and capricious.'" *Sullivan v. Zebley,* 110 S.Ct. 885, 890 (1990), *(quoting Bowen v. Yuchert,* 482 U.S. 137, 145 (1987), *quoting Heckler v. Campbell,* 461 U.S. 458, 466 (1983)). We cannot so find.

Given the language of the statute and the regulations, the Medical Center's request for a hearing before the Board of its 1985 base year cost report fails to "adhere to the administrative procedure which Congress has established for adjudicating [its] claims." *Heckler v. Ringer,* 466 U.S. 602, 619 (1984). We, therefore, conclude that the district court's order does not comport with a correct application of the controlling jurisdictional provision of the Medicare statute, 42 U.S.C. § 1395oo(a)(1), and must be reversed.[8]

IV. FEDERAL QUESTION JURISDICTION

The Medical Center contends, in the alternative, that 28 U.S.C. § 1331 confers subject matter jurisdiction on the district court to hear the Medical Center's claim.[9] The Secretary responds that the question of the availability of federal question jurisdiction under § 1331 is not property before the court. He argues that because 28 U.S.C. § 1331 was not asserted as a ground for jurisdiction in the district court that basis for relief was not properly preserved for appellate review.

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[8] Because of our decision we need not consider the Secretary's mootness argument since it is predicated on an assumption that we would otherwise affirm the district court's order.

[9] Section 1331 provides: "The district courts shall have original jurisdiction in all civil actions arising under the Constitution, laws or treaties of the United States."

The Medical Center tacitly concedes that § 1331 was not asserted as a jurisdictional basis in its complaint or in any other aspect of the district court proceedings. It does contend, *inter alia,* that "this case should be remanded to the district court with instructions to allow the Medical Center to amend its complaint so as to specifically assert general federal [question] jurisdiction...pursuant to 28 U.S.C. § 1331."

We conclude that in the exercise of our discretion and in the interests of justice this matter should be remanded to the district court to afford the Medical Center an opportunity to petition the district court for leave to amend its complaint. *See* 28 U.S.C. § 1653. *See generally Hahn v. United States,* 757 F.2d 581, 587 (3d Cir. 1985) (This court may, on appeal, consider whether jurisdiction was proper on grounds not asserted below). We do so for several reasons. First, the district court did not need to consider whether § 1331 could form a basis for jurisdiction over the Medical Center's claim because under its decision that issue did not need to be reached. Second, the Secretary does not suggest any reason why it would be prejudiced by this limited action. *See generally Gagliardi v. Flint,* 564 F.2d 112, 114-15 (3d Cir. 1977) (motion to amend jurisdictional statement to include reference to § 1331 jurisdiction may be granted absent a showing of prejudice to non-moving party with respect to issues tried in district court). If the Secretary does desire to assert prejudice that issue can be presented to the district court. Third, this court has been liberal in exercising its discretion to permit such amendments to be made in an attempt to cure defective allegations of jurisdiction. This is done in the interest of justice to avoid dismissal of suits on purely technical grounds. *Local No. I (ACA) v. International Brotherhood of Teamsters,* 614 F.2d 846, 853 (3d. Cir. 1980). For these reasons, a remand granting leave to seek permission to file such a request is granted.[10]

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[10] We do not decide at this time whether the hospital's claims may properly be asserted under this jurisdictional provision.

V. CONCLUSION

We conclude that the district court erred in deciding that the Medical Center's base year adjustment request met the amount in controversy requirement of § 1395oo(a) and that portion of the order must be reversed. We will, however, remand the cause to the district court to permit the Medical Center to file an application for leave to amend its complaint to assert a 28 U.S.C. §1331 basis for this action.

SCIRICA, *Circuit Judge,* concurring in part and dissenting in part.

I concur in the majority's decision to remand this case to allow the Medical Center to assert 28 U.S.C. § 1331 as a basis for jurisdiction in the district court. However, I respectfully dissent from the majority's conclusion that the Medical Center has failed to meet the jurisdictional requirements of 42 U.S.C. § 1395oo(a).

The Secretary's regulations provide, in part:

> (e) *Hospital requests regarding applicability of the rate of increase ceiling.* A hospital may request an exemption from, or exception or *adjustment to,* the rate of cost increase ceiling imposed under this section.... *HCFA's decision is subject to review under Subpart R of Part 405 of this chapter [i.e., by the PRRB].*

42 C.F.R. § 413.40(e) (emphasis added).

The Secretary's regulations further provide:

> (h) *Adjustments* — (1) *Comparability of cost reporting periods.* (i) HCFA may adjust the amount of the operating costs considered in establishing cost per case for one or more cost reporting periods, including both periods subject to the ceiling *and the hospital's base period,* to take into account factors

> that could result in a significant distortion in the operating costs of inpatient hospital services....

42 C.F.R. § 413.40(h)(1)(i) (emphasis added).

The Medical Center seeks, under 42 C.F.R. § 413.40(h), an adjustment to the base year costs that establish its cost per case and TEFRA increase ceilings. It contends that its base year costs were distorted by: (1) the inclusion of patients who were subsequently transferred to an acute care facility; and (2) the exclusion of physical expansion costs. In requesting an adjustment to its base year costs to account for these distortions, the Medical Center seeks to increase its reimbursable cost ceilings in subsequent years. It seems to me that the amount in controversy analysis in requests for such base year cost adjustments necessarily includes subsequent years, because the *effect* of granting the adjustment would be to increase reimbursable costs in subsequent years. Reimbursements in the base year would not be affected, because the adjustment is to "the amount of the operating costs considered in establishing cost per case" — *not* to the amount of operating costs actually reimbursed in the base year.

In cases involving group appeals, both the Fourth and Ninth Circuits have considered effects upon reimbursement in subsequent years in determining whether the amount in controversy requirement for PRRB jurisdiction was met. *White Memorial Medical Ctr. v. Schweiker,* 640 F.2d 1126, 1128 (9th Cir. 1981); *Cleveland Memorial Hosp. v. Califano,* 594 F.2d 993, 996 (4th Cir. 1979). As the United States Court of Appeals for the Fourth Circuit noted:

> The Board's distinction, by which one figure determines the scope of the appeal and another determines jurisdiction, is without foundation in either the statute or the applicable regulation. It is also unrelated to the purpose of the amount in controversy requirement,

> which is to ensure the substantiality of issues raised before the Board.

Cleveland Memorial Hosp., 594 F.2d at 996 (footnote omitted).

The Secretary contends that these cases are inapposite because the amount in controversy requirement in group appeals is "fundamentally different" from that in individual appeals. The PRRB has jurisdiction over group appeals from HCFA decisions if "the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more." 42 U.S.C. § 1395oo(b).

The amount in controversy requirement for group appeals differs from that for individual appeals only in the increase of the jurisdictional amount from $10,000 to $50,000, and by the addition of the phrase, "in the aggregate." *Compare* 42 U.S.C. § 1395oo(b) (group appeals) *with* 42 U.S.C. § 1395oo(a)(2) (individual appeals). The Secretary contends that it is only the phrase "in the aggregate" that permits consideration of effects in subsequent years to meet the amount in controversy requirement. A less strained construction of this statutory language would read "in the aggregate" to refer to the aggregation of the claims of multiple providers. I can discern no reason why the jurisdictional requirements in group appeals should be met by consideration of effects of requested adjustments upon reimbursement in subsequent years, whereas the jurisdictional requirements in individual appeals can be met by consideration only of the year for which the adjustment is requested.

Moreover, the Secretary's interpretation appears to contravene Congress's intent in enacting the amount in controversy requirement. The legislative history of § 1395oo, although relatively brief, shows a clear intent to provide independent review of reimbursement decisions by fiscal intermediaries which involve significant issues." *Cleveland Memorial Hosp.*, 594 F.2d at 996. The purpose of § 1395oo was to allow the

PRRB (and the federal courts) "to review and decide upon substantial reimbursement issues raised by providers of services." *Id.* (quoting H.R. Conf. Rep. No. 1407, *reprinted in* 1974 U.S.C.C.A.N. 5995-96) (Fourth Circuit's emphasis omitted). The Medical Center contends that the requested adjustment would result in its receipt of additional reimbursements of approximately $2,000,000 for the years 1986-88, and of approximately $700,000 for 1986 alone. These amounts appear to me to be both "significant" and "substantial."

Additional statutory support for the Medical Center's position is provided by 42 U.S.C. § 1395x(v)(1)(A) (entitled "Reasonable costs").[1] "Numerous courts have construed section 1395x(v)(1)(A) as imposing a statutory duty upon the Secretary to make suitable corrective adjustments whenever the amount of reimbursement determined by the chosen method of cost calculation fails to adequately reimburse all reasonable costs." *Regents of the Univ. of Cal. v. Heckler*, 771 F.2d 1182, 1188 (9th Cir. 1985) (citing and following cases imposing this duty). The Secretary's interpretation circumvents this statutory duty.

Finally, the Secretary's interpretation may well have the unfortunate consequence of preventing the kind of capital improvements that are largely responsible for the current controversy. Had the Medical Center not undertaken to improve its facility, it would not need an adjustment to its base year costs to correct the distortion caused by expenses stemming from capital improvements incurred in subsequent years. Congress cannot have intended such a result.

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[1] Title 42 U.S.C. § 1395x(v)(1)(A) provides, in pertinent part:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services. . .

42 U.S.C. § 1395x(v)(l)(A).

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

ST. FRANCIS MEDICAL CENTER,

Plaintiff,

v.

DONNA E. SHALALA,
Secretary of Health and Human Services, *et. al.,*

Defendants.

Civil Action No. 89-2452
Judge Ziegler
Magistrate Judge Sensenich

ORDER

AND NOW, this 30th day of July, 1993,

IT IS HEREBY ORDERED AND ADJUDGED in accordance with this Court's memorandum order of July 15, 1993, that defendants' motion to dismiss the amended complaint is GRANTED, the amended complaint is hereby DISMISSED, and that the clerk enter this judgment.

/s/ Donald E. Ziegler
DONALD E. ZIEGLER
United States District Judge

cc: Ila Jeanne Sensenich
Chief U.S. Magistrate Judge

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

ST. FRANCIS MEDICAL CENTER,

Plaintiff

vs.

LOUIS W. SULLIVAN, M.D.,
Secretary of the Department of
Health and Human Services;
LOUIS B. HAYES, Acting Administrator,
Health Care Financing Administration; and
ELISE D. SMITH, Chairman,Provider
Reimbursement Review Board,

Defendants

Civil Action No. 89-2452
Judge Donald E. Ziegler/
Magistrate Judge Sensenich
Re: Document#35
Received 7-16-93

MEMORANDUM ORDER

On December 20, 1989, this case was referred to United States Magistrate Judge Ila Jeanne Sensenich for pretrial proceedings in accordance with the Magistrates Act, 28 U.S.C. Section 636(b)(1)(A) and (B), and Rules 3 and 4 of the Local Rules for Magistrates.

The magistrate judge's report and recommendation, filed on May 25, 1993, recommended that defendants' motion to dismiss the amended complaint be granted. The parties were allowed ten (10) days from the date of service to file objections. Service was made on all parties and objections were filed by plaintiff on June 18, 1993. Defendants filed a response to the objections on July 9, 1993. After *de novo* review of the plead-

ings and documents in the case, together with the report and recommendation and objections thereto, the following order is entered:

AND NOW, this 15th day of July, 1993;

IT IS HEREBY ORDERED that defendants' motion to dismiss the amended complaint is granted.

The report and recommendation of Magistrate Judge Sensenich, dated May 25, 1993, is adopted as the opinion of the court.

/s/ Donald E. Ziegler
DONALD E. ZIEGLER
United States District Judge

cc: Ila Jeanne Sensenich
U.S. Magistrate Judge

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IN THE UNITED STATES DISTRICT COURT
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ST. FRANCIS MEDICAL CENTER,

Plaintiff

vs.

LOUIS W. SULLIVAN, M.D.,

Secretary of the Department of
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Acting Administrator, Health Care
Financing Administration; and
ELISE D. SMITH, Chairman, Provider
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Defendants

Civil Action No. 89-2452
Judge Donald E. Ziegler/
Magistrate Judge Sensenich
Re: Document#35

MAGISTRATE JUDGE'S
REPORT & RECOMMENDATION

I. RECOMMENDATION

It is recommended that defendants' motion to dismiss the amended complaint be granted.

II. REPORT

St. Francis Medical Center brings this action seeking an order declaring that the Department of Health and Human Services (HHS) and Louis Hayes, Acting Administrator of the Health Care Financing Administration (HCFA) have denied it equal protection by denying it reimbursement of its reasonable costs of its "distinct part rehabilitation unit" of its health care facility. Plaintiff also seeks an order directing HHS and HCFA

to recalculate its base year costs per discharge and award it the sums due resulting from the base year adjustment.

Defendant has filed a motion to dismiss pursuant to Rule 12(b) of the Federal Rules of Civil Procedure for lack of subject matter jurisdiction. Plaintiff's original complaint, which asserted this Court's jurisdiction under the Medicare Act, 42 U.S.C. § 1395oo(f)(1)[1], sought review of a decision of the Provider Reimbursement Review Board (PRRB) that it lacked jurisdiction to hear plaintiff's appeal concerning an adjustment to its base year cost report for providing services under the Medicare program established by Title XVIII of the Social Security Act, 42 U.S.C. § 1395. Defendants' first motion to dismiss asserted that the court's jurisdiction was limited to whether the PRRB had jurisdiction over plaintiff's claims for the year 1985. It further argued that it did not because the amount in controversy did not exceed $10,000.00 as required by 42 U.S.C. § 1395oo(a)(2). Although plaintiff admitted that a recalculation of its base year costs would result in it owing Medicare almost $500,000.00 for the year 1985, it claimed that Medicare would owe it almost $2,000,000.00 for 1986, 1987 and 1988 based on an adjustment to the base year cost report. Since plaintiff could satisfy the $10,000.00 jurisdiction amount as defined in 42 C.F.R. § 405.1839(a)(2) by the years 1986, 1987 and 1988, it was recommended that the motion to dismiss be denied. The report and recommendation was adopted on April

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[1] The Medicare Act authorizes federal jurisdiction over final decisions of the Board. 42 U.S.C. § 1395oo(f)(1) provides in part:

> A decision of the Board shall be final unless the Secretary, . . . reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance or modification by the Secretary as received.

26, 1991. Defendants' motion to dismiss was denied and the action was remanded to the PRRB for review on the merits.

Defendants appealed to the Court of Appeals for the Third Circuit which reversed on the ground that plaintiff had not satisfied the amount in controversy requirement of § 1395oo(a). The court however remanded the case to this court to permit the plaintiff to file an application for leave to amend its complaint to assert jurisdiction under 28 U.S.C. § 1331.

Upon remand the complaint was amended and defendants' instant motion to dismiss was filed. The question is whether, although plaintiff is precluded from judicial review of its base year adjustment request for 1985 because it did not satisfy the amount in controversy requirement found in 42 U.S.C. §1395oo(a), it can proceed to obtain the same relief under 28 U.S.C. § 1331. Since plaintiff cannot satisfy the requirements for judicial review pursuant to 42 U.S.C. § 1395oo(f)(1) it cannot proceed under § 1331.

The factual background and procedural history of this case is discussed in the reported opinion at *St. Francis Medical Center v. Sullivan,* 962 F.2d 1110, 1111-1113 (3d Cir. 1992). Defendants base their argument that this court does not have jurisdiction over this action pursuant to 28 U.S.C. § 1331 on *Heckler v. Ringer,* 466 U.S. 602 (1984) and cases following it. In that case the Court held that the plaintiffs, who were Medicare claimants, could not obtain judicial review of their claims for benefits pursuant to 28 U.S.C. § 1331 where they had failed to satisfy the exhaustion requirement of 42 U.S.C. § 405(g). Although they presented their claim as a constitutional issue—that the Secretary's instructions to its intermediaries violated due process and the Act, their claims were "inextricably intertwined" with their claims for benefits. They argued that what they were objecting to was the Secretary's procedure for reaching her decision, but the relief they sought was invalidation of the Secretary's policy and a substantive declaration from her that

the expenses of the surgery they sought were reimbursable under the Medicare Act. The Court concluded that all aspects of their claim for benefits should be channeled first into the administrative process which Congress had provided for the determination of claims for benefits. The Medicare Act, 42 U.S.C. § 1395ii incorporates the provisions of 42 U.S.C. § 405(h), which limits judicial review of findings and decisions of the Secretary to the limited review available under 42 U.S.C. Section 405(g), and specifically states:

> No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h). The Court stated:

> Thus, to be true to the language of the statute, the inquiry in determining whether § 405(h) bars federal question jurisdiction must be whether the claim "arises under" the Act, not whether it lends itself to a "substantive" rather than a "procedural" label.

466 U.S. 615. The Court referred to its earlier decision in *Weinberger v. Salfi*, 422 U.S. 749 (1975) and stated:

> We construe the "claim arising under" language quite broadly to include any claims in which "both the standing and the substantive basis for the presentation" of the claims is a Social Security Act. In that case we held that a constitutional challenge to the duration-of-relationship eligibility statute pursuant to which the claimant had been denied benefits, was a "claim arising under" Title II of the Social Security Act within the meaning of 42 U.S.C. § 405(h), even though we recognized that it was in one sense also a claim arising under the Constitution.

466 U.S. 615.

Plaintiff cites *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), in support of its argument that this court has jurisdiction pursuant to 28 U.S.C. § 1331. In that case the Court held that § 405(h), as incorporated in the Medicare Program by § 1395ii, did not preclude an action filed under 28 U.S.C. § 1331 challenging a regulation promulgated under Part B which authorized payment of benefits in different amounts for similar physician services. Part A of the Act provides for mandatory institutional health benefits, such as coverage for hospital expenses. Plaintiff's instant claim is under Part A. Part B provides optional, federally subsidized coverage supplemental to the mandatory institutional benefits provided by Part A. Under Part A an individual is entitled to a hearing before the Secretary with a right to judicial review. Under Part B, until the Medicare Act was amended effective October 21, 1986, an aggrieved individual was entitled to a hearing by the *carrier* without the right to judicial review. Therefore, a critical distinction between the instant action and *Michigan Academy* is that plaintiff's claim is under Part A under which judicial review is available, provided the requirements are satisfied, one of which is that the claim involve at least $10,000. However, when *Michigan Academy* was decided there was no right to judicial review for claims under Part B. The Court started by recognizing a strong presumption that Congress intends judicial review of administrative action and that "only upon a showing of 'clear and convincing evidence' of a contrary legislative intent should the courts restrict access to judicial review." 476 U.S. at 671. The Court rejected the government's assertion that 42 U.S.C. § 1395ii which makes 42 U.S.C. § 405(h) of the Social Security Act applicable to the Medicare Program expressly precluded all administrative or judicial review not otherwise provided in that statute. 476 U.S. at 673. The Court noted that the Act provides the forum and limits of review of:

> "any determination . . . of . . . the amount of benefits under Part A," . . . and of the "amount of . . . payment"

> of benefits under Part B . . . simply does not speak to challenges mounted against the *method* by which such amounts are to be determined rather than the *determinations* themselves.

476 U.S. at 675. The Court therefore stated:

> As a result, an attack on the validity of a regulation is not the kind of administrative action that we described in *Erika* as an "amount determination" which decides "the amount of the Medicare payment to be made on a particular claim" and with respect to which the Act impliedly denies judicial review.

476 U.S. at 676. The Court held that Congress did not preclude judicial review of the method by which Part B awards were computed.

American Ambulance Service v. Sullivan, 911 F.2d 901 (3d Cir. 1990), cited by plaintiff as authority for this court's jurisdiction under 28 U.S.C. § 1331 was a claim under Part B of the Medicare program. In that case the plaintiff was challenging a Carrier's Manual and Regional Letters which hearing officers used to evaluate claims, which the plaintiff claimed imposed requirements that were not imposed by the Act and constituted a rule which was invalid because it had not been subjected to notice and comment rule making. The Court found there was jurisdiction because the plaintiff was challenging the validity of an agency rule. The Court of Appeals found that the district court had jurisdiction because the plaintiff was challenging the means by which the hearing officer made her determination.

In *Westchester Management v. U.S. DHHS,* 948 F.2d 279 (6th Cir. 1991), which involved a claim under Part A, the court held that the district court did not have subject matter jurisdiction over the action which claimed that the plaintiff was denied due process by the hearing officer's disallowance of its claim which was based on a provision in the Medicare Provider

Reimbursement Manual, which the hearing officer noted he lacked authority to disobey. The court found the district court did not have jurisdiction under 42 U.S.C. § 1395oo(f)(1) because the amount in controversy did not exceed $10,000.00. Further, the court did not have jurisdiction under § 1331 because 42 U.S.C. § 1395ii incorporates into the Medicare Act, 42 U.S.C. § 405(h) which limits judicial review of actions "arising under this subchapter."

The plaintiff claimed that it was challenging an instruction of the Secretary which was contained in a Provider Manual, not an amount determination but the court found that the action was one "arising under" the Medicare Act. The court stated that the Supreme Court has found:

> That constitutional and statutory challenges to an instruction of the Secretary, such as Westchester Management's challenge here, arise under the Medicare Act.

948 F.2d 282. The court added that where Congress creates a forum for judicial review, claimants must satisfy all requirements. It stated that *Michigan Academy*, *supra*, only applies where there is no other avenue of judicial review. Since Congress had provided for judicial review for this type of claim under the Medicare Act, plaintiff could not bring an action under § 1331 merely because it did not satisfy all the requirements for judicial review under the Medicare Act.

In *National Kidney Patients Ass'n v. Sullivan*, 958 F.2d 1127 (D.C. Cir. 1992), a case involving a claim under Part B, the court noted that resolution of the jurisdictional issue required a choice between two lines of precedent. *Heckler v. Ringer*, *supra*, and other cases which construed §§ 405(g) and 405(h) of the Social Security Act as establishing a rigorous scheme which must be satisfied before judicial review is available. On the other side was the rule the Supreme Court had developed in *Michigan*

Academy, supra, for Medicare Part B disputes, prior to the 1986 Amendment to the Medicare Act. The Court stated:

> Under this approach, disputes over "amounts" were (per statute) completely removed from judicial review, . . . whereas disputes over "methodology" could be brought under 28 U.S.C. § 1331's provision for general federal question jurisdiction, subject only to conventional exhaustion requirements.

958 F.2d 1130. The court determined that because Congress had by the October 21, 1986 amendment to the Medicare Act extended judicial review to claims under Part B as well as claims under Part A, the court no longer had jurisdiction over Part B disputes under § 1331.

Plaintiff's claim is brought under Part A and judicial review is precluded because plaintiff did not satisfy the jurisdictional amount requirement for a hearing before the PRRB. Plaintiff cannot avoid this requirement by asserting jurisdiction under 28 U.S.C. § 1331.

Plaintiff argues that this court should broadly extend jurisdiction over its claim under the *Michigan Academy, supra,* line of cases because its reimbursement for the years following 1985 is based upon its base year cost reporting period of 1985 which it claims underestimated its rehabilitation unit's actual costs in later years because of substantial changes that occurred in its rehabilitation unit. Plaintiff argues that if it is precluded from judicial review of its base year costs for 1985 because it has not satisfied the jurisdictional amount requirement, then it is precluded from judicial review of its reimbursement in future years. However, the defendants note that the regulations, 42 C.F.R. § 413.40(g)(1), specifically authorized base period cost adjustments, both in the actual base period and in later periods subject to the TEFRA limits. See also, 42 U.S.C. § 1395ww(b)(4)(A).

Plaintiff refers to *Community Hosp. of Chandler, Inc. v. Sullivan,* 963 F.2d 1206 (9th Cir. 1992), where the court noted that the Secretary had not promulgated regulations which would make clear to a facility in the plaintiff's position the procedure for requesting a base-year cost adjustment pursuant to 42 U.S.C. § 1395ww(b)(4)(A). In *Community Hosp.* the court held that since the plaintiff had experienced distortions in the costs for the base period, the Secretary's failure to make some adjustments to the base-year cost figure violated the requirement in 42 U.S.C. § 1395ww(b)(4)(A) that the Secretary "*shall* provide for an exemption from, or an exception [and] adjustment to" the normal process of calculating the hospital's base-year cost. 963 F.2d 1214. This case actually supports defendants' argument that plaintiff has a remedy for claims for which it can satisfy the jurisdictional requirements for judicial review.

Plaintiff amended its complaint to assert jurisdiction under 28 U.S.C. § 1331 because the Court of Appeals held that the PRRB did not have jurisdiction to grant its request for a hearing because its claim did not involve an amount of $10,000.00 or more. However, § 1331 cannot be used as an alternate basis to obtain jurisdiction where the plaintiff has not satisfied the requirements for judicial review under 42 U.S.C. § 1395oo(f)(1) and 42 U.S.C. § 405(g). Therefore, it is recommended that defendants' motion to dismiss be granted.

In accordance with the Magistrates Act, 28 U.S.C. § 636(b)(1)(B) and (C), and Rule 4 of the Local Rules for Magistrates, the parties are allowed ten (10) days from the date of service to file objections to this report and recommendation.

/s/
ILA JEANNE SENSENICH
Chief U.S. Magistrate Judge

Dated: May 25, 1993

cc: The Honorable Donald E. Ziegler
United States District Judge

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IN THE UNITED STATES DISTRICT COURT
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Secretary of the Department of
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LOUIS B. HAYES, Acting Administrator
Health Care Financing Administration

ELISE D. SMITH, Chairman, Provider
Reimbursement Review Board,

Defendants

Civil Action No. 89-2452

JUDGMENT

AND NOW, this 2nd day of July, 1991,

IT IS HEREBY ORDERED AND ADJUDGED that this case be remanded to the Provider Reimbursement Review Board for review on the merits and that the clerk enter this judgment.

/s/ Donald E. Ziegler
DONALD E. ZIEGLER
United States District Judge

cc: Ila Jeanne Sensenich
Chief U.S. Magistrate Judge

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IN THE UNITED STATES DISTRICT COURT
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Secretary of the Department of
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Financing Administration; and
ELISE D. SMITH, Chairman,
Provider Reimbursement Review Board,

Defendants.

Civil Action No. 89-2452
Judge Donald E. Ziegler/
Magistrate Sensenich

MEMORANDUM ORDER

On December 20, 1989, this case was referred to Chief United States Magistrate Judge Ila Jeanne Sensenich for pretrial proceedings in accordance with the Magistrates Act, 28 U.S.C. Section 636(b)(1)(A) and (B), and Rules 3 and 4 of the Local Rules for Magistrates.

The magistrate judge's report and recommendation, filed on February 1, 1991, recommended that defendants' motion to dismiss be denied and the case be remanded to the Provider Reimbursement Review Board for review on the merits. The parties were allowed ten (10) days from the date of service to file objections. Service was made on all parties and by order of March 1, 1991, defendants were allowed until April 19, 1991 to

file objections to the report and recommendation. Objections were filed by defendants on April 19, 1991. After *de novo* review of the pleadings and documents in the case, together with the report and recommendation and objections thereto, the following order is entered:

AND NOW, this 26th day of April, 1991;

IT IS HEREBY ORDERED that defendants' motion to dismiss is denied and the case is remanded to the Provider Reimbursement Review Board for review on the merits.

The report and recommendation of Chief Magistrate Judge Sensenich, dated February 1, 1991, is adopted as the opinion of the court.

/s/ Donald E. Ziegler
DONALD E. ZIEGLER
United States District
Judge

cc: Ila Jeanne Sensenich
Chief U.S. Magistrate Judge

Stephen P. Nash, Esquire
Domenic A. Bellisario, Esquire
700 Westinghouse Building
Pittsburgh, PA 15222

Albert W. Schollaert
Assistant U.S. Attorney
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Barbara H. Fisher, Attorney
Health Care Financing Division
Office of the General Counsel
Department of Health and Human Services
Room 500 East High Rise Building
6325 Security Boulevard
Baltimore, MD 21207

CLERK'S OFFICE

United States District Court
FOR THE
WESTERN DISTRICT OF PENNSYLVANIA

ST. FRANCIS MEDICAL CENTER

vs.

LOUIS W. SULLIVAN, M.D.

Civil Action No. 89-2452

There was entered on the docket 4-26-91, 19
an order

/s/ Catherine D. Martrano , CLERK

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF PENNSYLVANIA

ST. FRANCIS MEDICAL CENTER,

Plaintiff

vs.

LOUIS W. SULLIVAN, M.D.,
Secretary of the Department
of Health and Human Services;
LOUIS B. HAYES, Acting Administrator,
Health Care Financing Administration; and
ELISE D. SMITH, Chairman,
Provider Reimbursement ReviewBoard,

Defendants

Civil Action No. 89-2452
Judge Donald E. Ziegler/
Magistrate Judge Sensenich

MAGISTRATE JUDGE'S
REPORT AND RECOMMENDATION

I. RECOMMENDATION

It is recommended that defendants' motion to dismiss be denied and the case be remanded to the Provider Reimbursement Review Board for review on the merits.

II. REPORT

St. Francis Medical Center brings this action against Louis Sullivan, Secretary of the Department of Health and Human Services (DHHS), Louis Hayes, Acting Administrator of the Health Care Financing Administration (HCFA), and Elise Smith, Chairperson of the Provider Reimbursement Review Board (PRRB), seeking review of the PRRB's decision that it

lacked jurisdiction to hear St. Francis' appeal concerning an adjustment to its base year cost report for providing services under the Medicare program established by Title XVIII of the Social Security Act, 42 U.S.C. Section 1395, *et seq.*

St. Francis is a health care facility which operates a "distinct part rehabilitation unit" (DPU) and an acute care facility, both of which are approved as "providers of services" under the Medicare program. Providers enter into contracts with the DHHS to provide Medicare services to eligible individuals. These individuals are not charged for the services they receive (other than for copayment and deductible amounts) and the provider is paid through Medicare under one of two systems.

Until October 1, 1983, a provider was reimbursed for the lesser of its reasonable costs or its customary charges, known as the cost based, retrospective system. The Medicare statute defined what reasonable costs were and authorized the Secretary to set limits. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), authorized the Secretary to establish additional limits on reasonable costs reimbursement. The TEFRA limits were intended to restrain increases in Medicare payments by setting "target amounts" for participating hospitals. The target amounts are based on a provider's allowable in-patient operating costs per case incurred in its "base year." Hospitals whose costs are less than or equal to their target amounts are entitled to bonuses, while hospitals whose costs are greater than their target amounts are reimbursed only for the target amount.

The Social Security Amendments of 1983 changed the cost reporting system after October 1, 1983, wherein providers were no longer reimbursed for their costs but were paid in accordance with the Medicare Prospective Payment System (PPS). Certain excluded facilities, however, were to remain under the cost based system with the TEFRA rate of increase limits. These facilities include DPU's of hospitals which are exempt from the PPS if at least 75% of the in-patients treated in the unit during

its latest cost reporting period required intensive rehabilitative services.

At the end of the cost year, a provider must submit a cost report to a fiscal intermediary which reviews the report and determines what portion is reimbursable under Medicare. In determining the costs of a DPU, a provider must allocate overall expenses between the general facility and the unit. The intermediary issues the provider a "Notice of Program Reimbursement" (NPR) setting forth the final amount the provider will be reimbursed. If the provider is dissatisfied with the intermediary's determination, it may request a hearing through the intermediary before the HCFA. If the provider is dissatisfied with the HCFA's determination, it can seek review by appealing to the PRRB. The board's decision is final unless the Secretary affirms, reverses or modifies it, and in any event, the provider may seek review in the district court.

In its first year of program participation, plaintiff was required to submit a cost report for its base year, fiscal year ending June 30, 1985, with costs associated with the DPU separate from the general facility. The DPU is excluded from the PPS so reimbursement is made under the cost based reimbursement system, which includes the TEFRA limits. In May of 1985, however, the DHHS informed plaintiff that its DPU would not be exempt from the PPS due to "non true rehabilitation patients" being treated, such as quadriplegic and paraplegic patients. St. Francis transferred these patients to the acute care facility to maintain the DPU's exempt status.

Plaintiff filed its 1985 cost report with the intermediary in October of 1985. As a result of including the costs incurred for the transferred patients in with the DPU's costs, the average length of stay of the unit's base year patients and the costs per discharge was lower than it should have been. The base year cost report also did not include costs associated with a physical expansion project which was completed in 1986.

The intermediary used the figures in the 1985 cost report to calculate plaintiff's TEFRA ceiling. Plaintiff exceeded its TEFRA rate of increase limits for the years 1986, 1987 and 1988. Plaintiff claims it has been subjected to an improper and unreasonable TEFRA ceiling during the years subsequent to the base year and as a result, has been deprived of its entitlement to reimbursement for its reasonable costs or from obtaining incentive payments it would otherwise receive. Plaintiff submitted an amended cost report to the intermediary seeking an adjustment to its original cost report to reflect the physical expansion costs and to exclude the costs associated with the transferred patients. The intermediary denied permission to plaintiff to amend or reopen its original report and advised it to file an exception to the 1986 TEFRA ceiling.

Plaintiff appealed the intermediary's decision to the PRRB and also sought review of an HCFA decision denying an exception to the TEFRA ceiling for fiscal year ending June 30, 1986. The PRRB accepted jurisdiction over plaintiff's appeal from the HCFA decision but claimed it did not have jurisdiction over the base year adjustment appeal. The board denied jurisdiction because it found the amount in controversy did not exceed $10,000.00 as required by 42 U.S.C. Section 1395oo(a)(2). Plaintiff concedes that a recalculation of its base year costs would result in it owing Medicare almost $500,000.00. However, it claims Medicare would owe it almost $2,000,000.00 for 1986, 1987 and 1988 based on an adjustment to the base year cost report. Plaintiff argues that PRRB should assume jurisdiction over the appeal concerning the base year cost report adjustments because it is the basis for the relief requested in the 1986 appeal.[1]

---

[1] This court's review at this time is limited to whether the PRRB's denial of jurisdiction was appropriate and does not extend to the merits of the case. *See McKeesport Hospital v. Heckler*, 612 F. Supp. 279, 282 (W.D. Pa. 1985).

The statute provides as follows:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—
>
> (1) . . .
>
> (2) the amount in controversy is $10,000.00 or more[.]

42 U.S.C. Section 1395oo(a)(2).

The government contends the amount in controversy must be a *positive* $10,000.00 or more, not a negative number, i.e. a provider must claim Medicare owes it $10,000.00 or more. Instead, plaintiff concedes it would owe Medicare approximately $500,000.00 for fiscal year ending June 30, 1985. Defendants argue that the years subsequent to 1985, wherein plaintiff claims Medicare would owe it approximately $2,000,000.00 are not at issue in this case because plaintiff is only challenging the calculation of its base year costs. Defendants point out that if the plaintiff is dissatisfied with the TEFRA limits for any year after 1985 it can request an exemption, exception or adjustment to the target amount pursuant to 42 C.F.R. Section 413.40(f), (g) and (h). Furthermore, if plaintiff is dissatisfied with the action taken on a request for any such

exemption, exception or adjustment, it can appeal to the PRRB and, if necessary, to the courts. This solution, however, would require plaintiff to take administrative and possibly judicial action every year solely because of an allegedly inaccurate base year cost report.

Defendants argue the PRRB properly interpreted 42 C.F.R. Section 405.1839 which defines the $10,000.00 amount in controversy requirement as follows:

> (a) Single Appeals. The $1,000.00 amount in controversy required under Section 405.1809 for an intermediary hearing and the $10,000.00 amount in controversy required under Section 405.1835 for a board hearing is, as applicable to the matters for which the provider has requested the hearing, the combined total of the amounts computed as follows:
>
> * * *
>
> (a) (2) Providers Not Under Prospective Payment. For providers that are not paid under the prospective payment system, by deducting the adjusted total reimbursable program costs due to the provider on a reasonable cost basis from the total reimbursable costs claimed by the provider.

42 C.F.R. Section 405.1839(a)(2). Although the defendants claim that the PRRB was correct in finding that plaintiff failed to meet the amount in controversy requirement for the base year appeal under the definition above, this interpretation ignores the fact that the base year cost report sets the TEFRA limits for all subsequent years. While the courts are required to give deference to the board's interpretation of the statute, they are not bound by it.

> "Judicial review of Medicare reimbursement decisions is governed by the Administrative Procedure

> Act, 5 U.S.C. Sections 701-06 (1982), which requires a court to set aside agency actions found to be 'arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law . . .' *Id.* at Section 706." *Regents [of the University of California v. Heckler]*, 771 F.2d at 1187. Although an agency's interpretation of the statutory scheme under which it operates is entitled to considerable deference, we must reject an agency's interpretation that is inconsistent with the statute's meaning. *Vance [v. Hegstrom]*, 793 F.2d at 1023; *Regents,* 771 F.2d at 1187.

Sunshine Health Systems, Inc. v. Bowen, 809 F.2d 1390, 1394 (9th Cir. 1987).

The PRRB's denial of jurisdiction in this matter appears to be arbitrary and capricious. The basis of the controversy between plaintiff and defendants is the base year cost report which allegedly contains inaccurate information affecting the reimbursement plaintiff receives from Medicare for subsequent years because the TEFRA rate of increase limits were set according to the base year cost report. The PRRB attempts to isolate each year involved to determine whether it meets the $10,000.00 requirement, but the claim requires the board to look at the years 1985 through 1988 as a whole because they are inextricably connected, since the base year is the foundation for a continuing inaccuracy in plaintiff's reimbursements from Medicare. Plaintiff easily meets the $10,000.00 jurisdictional amount as defined in 42 C.F.R. Section 405.1839(a)(2) for the years 1986, 1987 and 1988, for which the TEFRA rate of increase limits are determined by the 1985 cost report. It is unreasonable and inefficient to require plaintiff to file annually for an exception to the TEFRA limits when a recalculation of the base year cost report, if proven to be inaccurate, would obviate the problem. Therefore, it is recommended that defendants' motion to dismiss

be denied and the case be remanded to the PRRB for review on the merits.

In accordance with the Magistrates Act, 28 U.S.C. Section 636(b)(1)(B) and (C), and Rule 4 of the Local Rules for Magistrates, the parties are allowed ten (10) days from the date of service to file objections to this report and recommendation.

/s/
ILA JEANNE SENSENICH
Chief U.S. Magistrate Judge

Dated: February 1, 1991

cc: Stephen P. Nash, Esquire
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700 Westinghouse Building
Pittsburgh, PA 15222

Albert W. Schollaert
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

OCT. 19, 1989

Case No.: 88-1039

CERTIFIED MAIL

Steve Nash, Esquire
Nash & Co.
700 Westinghouse Building
Pittsburgh, PA 15222

Re: St. Francis Medical Center — Distinct Part Rehab Unit, Pittsburgh, PA, Provider No. 39-T029, Case No. 88-1039, FYE — June 30, 1985

The Provider Reimbursement Review Board (Board) has reviewed the documentation submitted in the above-captioned case, and the Board finds that it does not have jursidiction over the subject year.

Under Section 1878(a) Title XVIII, Social Security Act, as amended, and 42 CFR 405.1835 and 1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary (NPR), and the amount in controversy is $10,000, or more, and the request for hearing was filed within 180 days of the date of the final determination.

In this case, the Board finds that a final determination with regard to the issues you are appealing was not made by your Intermediary. Although you contend that an amended cost report which raised the appealed issues was filed with your Intermediary, the Board finds that an amended cost report was not filed. In addition, the amount in controversy for the issues you wish to raise is less than $10,000. Since the above statutory requirement is a prerequisite to a provider's right to a hearing, the Board finds that it does not have jurisdiction over this appeal and hearby dismisses the appeal of the subject year.

This determination is subject to the provisions of 42 CFR 1875 and 1877 (Section 1878 (f) of the Social Security Act, as amended).

Board Members Participating:

Elise D. Smith
Arthur P. Owens
Keith E. Braganza
Sally A. Kirkpatrick

FOR THE BOARD: Elise D. Smith
Chairman

Enclosures
Sections 1878(f)(1) of the
Social Security Act, as amended /s/ AK 10/19
42 C.F.R. 405.1875 /s/ Braganza 10/19
42 C.F.R. 405.1877 /s/ Smith 10/19

cc: Dean W. Eckenrode, BC of Western Pennsylvania
Michael F. Berkey, CPA, BC&BSA

UNITED STATES COURT OF APPEALS

FOR THE THIRD CIRCUIT

No. 93-3405

ST. FRANCIS MEDICAL CENTER,

Appellant

v.

DONNA E. SHALALA, Secretary of the Department of Health and Human Services, BRUCE C. VLADECK, Administrator, Health Care Financing Administration; and JACK MARTIN, Chairman, Provider Reimbursement Review Board

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(D.C. Civil No. 89-02452)

SUR PETITION FOR REHEARING

Present: SLOVITER, *Chief Judge*
BECKER, STAPLETON, MANSMANN, GREENBERG, HUTCHINSON, SCIRICA, COWEN, NYGAARD, ALITO, ROTH, LEWIS, and McKEE, *Circuit Judges* and PARELL, *District Judge* *

The petition for rehearing filed by appellant in the above-entitled case having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the Court in banc the petition for rehearing is denied.

---

* The Honorable Mary Little Parell, United States District Court Judge for the District of New Jersey, sitting by designation, as to panel rehearing only.

BY THE COURT,

/s/_____
Circuit Judge

DATED: SEP 27, 1994

October 6, 1994

UNITED STATES COURT OF APPEALS

FOR THE THIRD CIRCUIT

No. 93-3405

St. Francis Medical Center v. Secretary, HHS

Present: ALITO, *Circuit Judge*

1. Motion by Appellant to Have Its Petition for Rehearing Submitted to All Judges Who Participated in Deciding Both St. Francis I and St. Francis II.

2. Motion by Appellant for a Stay of Mandate, pending ruling on the above motion.

3. For your information, the opinion was filed and judgment entered on August 9, 1994.
The Petition for In Banc Rehearing was denied by all active Judges and District Judge Parell on September 27, 1994. Senior Circuit Judge Seitz did not participate in the vote.

3. Counsel for Appellees has advised that a response will not be filed.

/s/
Kathleen O'Toole
Deputy Clerk
Direct Dial: 597-5846

ORDER

The foregoing Motions are: denied.

By the Court,

/s/
Circuit Judge

Dated: OCT 21, 1994

OFFICE OF THE CLERK
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

21400 United States Courthouse
601 Market Street
Philadelphia PA 19106-1790
Tel. 215-597-5846
October 21, 1994
P. Douglas Sisk, Clerk

Mr. Alfred L. Wilson, Clerk
U.S. District Court for the
Western District of Pennsylvania
P.O. Box 1805 Pittsburgh, PA 15230

Re: Docket No. 93-3405
St Francis Med Ctr vs. Secretary HHS
D. C. Civ. No. 89-02452

Dear Mr. Wilson:

Enclosed is a certified copy of the judgment order in the above-entitled case(s). The certified judgment order is issued in lieu of a formal mandate and is to be treated in all respects as a mandate.

We release herewith the certified list in lieu of the record.

Kindly acknowledge receipt for same on the enclosed copy of this letter.

Counsel are advised of the issuance of the mandate by copy of this letter. A copy of the certified judgment order is enclosed showing costs taxed, if any. **Also enclosed is copy of order, filed today.**

Very truly yours,
P. DOUGLAS SISK, CLERK

/s/
By: Kathleen O'Toole
Deputy Clerk

Enclosure

cc : (Stephen P. Nash, Esq.
(David W. Thomas, Esq.
(Melinda J. Roberts, Esq.
Gerard Keating, Esq.
Barbara H. Fisher, Esq.
Paul J. Brysh, Esq.

UNITED STATES COURT OF APPEALS

FOR THE THIRD CIRCUIT

No. 93-3405

ST. FRANCIS MEDICAL CENTER,

Appellant

v.

DONNA E. SHALALA, Secretary of the Department of Health and Human Services, BRUCE C. VLADECK, Administrator, Health Care Financing Administration; and JACK MARTIN, Chairman, Provider Reimbursement Review Board

---

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF PENNSYLVANIA

(D.C. Civil No. 89-02452)

Present: Sloviter, *Chief Judge*, Alito, *Circuit Judge*, and Parell, *District Judge**

JUDGMENT

This cause came to be heard on the record from the United States District Court for the Western District of Pennsylvania and was argued on March 2, 1994.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said District Court entered July 30, 1993, be, and the same is hereby affirmed.

---

* The Honorable Mary Little Parell, U. S. District Court Judge for the District of New Jersey, sitting by designation.

Costs taxed against appellant. All of the above in accordance with the opinion of this Court.

ATTEST:

/s/_____
Chief Deputy Clerk

Dated: August 9, 1994

Costs taxed in favor of Appellees, Secretary, HHS, et al., as follows:

Brief...	$247.60
TOTAL...	$247.60

Certified as a true copy and issued in lieu of a formal mandate on October 21, 1994.

Teste: /s/_____
Chief Deputy Clerk, U.S. Court of Appeals for the Third Circuit.

42 USC 1395oo(a)

§ 1395oo. Provider Reimbursement Review Board

(a) Establishment. Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1886 [42 USCS § 1395ww(b) or (d)] and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 [42 USCS § 1395h] as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title [42 USCS §§ 1395 *et seq.*] for the period covered by such report, or
(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1886 [42 USCS § 1395ww(b) or (d)],

(B) has not received such final determination from such intermediary on a timely

basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or, with respect to appeals under paragraph (l)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

42 USC § 1395ww(b)(4)

(4)(A) The Secretary shall provide for an exemption from, or an exception and adjustment to, the method under this subsection for determining the amount of payment to a hospital where events beyond the hospital's control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, *including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and** including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

(B) In determining under subparagraph (A) whether to assign a new base period which is more representative of the reasonable and necessary cost to a hospital of providing inpatient services, the Secretary shall take into consideration —

(i) changes in applicable technologies and medi-

---

* The italicized language was not included in this Section in 1986, but was added to this Section by the Act December 19, 1989 Section 6015(a).

cal practices, or differences in the severity of illness among patients, that increase the hospital's costs;

(ii) whether increases in wages and wage-related costs for hospitals located in the geographic area in which the hospital is located exceed the average of the increases in such costs paid by hospitals in the United States; and

(iii) such other factors as the Secretary considers appropriate in determining increases in the hospital's costs of providing inpatient services.

(C) Paragraph (1) shall not apply to payment of hospitals which is otherwise determined under paragraph (3) of section 1814(b) [42 USCS § 1395f(b)(3)].

42 CFR § 413.40(g)-(i)

(g) *Adjustments*(1) *General rule.* HCFA must adjust the amount of the operating costs considered in establishing the rate-of-increase ceiling for one or more cost reporting periods, including both periods subject to the ceiling and the hospital's base period, under the circumstances specified below. When an adjustment is requested by the hospital, HCFA makes an adjustment only to the extent that the hospital's operating costs are reasonable, attributable to the circumstances specified, separately identified by the hospital, and verified by the intermediary. HCFA may grant an adjustment requested by the hospital only if a hospital's operating costs exceed the rate-of-increase ceiling imposed under this section.

(2) *Extraordinary circumstances.* HCFA may make an adjustment to take into account unusual costs (in either a cost reporting period subject to the ceiling or the hospital's base period) due to extraordinary circumstances beyond the hospital's control. These circumstances include, but are not limited to, strikes, fire, earthquakes, floods, or similar unusual occurrences with substantial cost effects.

(3) *Comparability of cost reporting periods*—(i) *Adjustment for distortion.* HCFA may make an adjustment to take into account factors that would result in a significant distortion in the operating costs of inpatient hospital services between the base year and the cost reporting period subject to the limits.

(ii) *Factors.* The adjustments described in paragraph (g)(3)(i) of this section, include, but are not limited to, adjustments to take into account:

(A) FICA taxes (if the hospital did not incur costs for FICA taxes in its base period).

(B) Services billed under part B of Medicare during the base period, but paid under part A during the subject cost reporting period.

(C) Malpractice insurance costs (if malpractice costs were not included in the base year operating costs).

(D) Increases in service intensity or length of stay attributable to changes in the type of patient served.

(E) A change in the inpatient hospital services that a hospital provides, and that are customarily provided directly by similar hospitals, such as an addition or discontinuation of services or treatment programs.

(F) The manipulation of discharges to increase reimbursement.

(iii) *Adjusting operating costs.* Without a formal request from a hospital HCFA may adjust the amount of operating costs, determined under paragraph (c)(1) of this section, to take into account adjustments under paragraphs (g)(3)(ii) (A), (B), (E), and (F) of this section.

(4) *Significant wage increase*—(i) *Criteria.* HFCA may make an adjustment to take into account a significant increase in wages occurring between the base period and the cost reporting period subject to the ceiling if the increase in the average hourly wage for the geographic area in which the hospital is located (determined by reference to the wage index for prospective payment hospitals without regard to geographic reclassifications under sections 1886(d) (8) and (10) of the Act) meets one of the following criteria:

(A) The wage index value based on 1988 wage data is at least 8.0 percent higher than the wage index value based on 1982 wage data.

(B) If the hospital's base period begins in FY 1984 or later, the wage index value based on 1988 wage data is at least 8.0

percent higher than the wage index value based on 1984 wage data.

(ii) *Amount of the adjustment.* The adjustment for a significant wage increase equals the amount by which the lesser of the following calculations exceeds 105 percent of the increase in the national average hourly earnings for hospital workers:

(A) The rate of increase in the average hourly wage in the geographic area (determined by applying the applicable increase in the area wage index value to the rate of increase in the national average hourly earnings for hospital workers).

(B) The rate of increase in the hospital's average hourly wage.

(h) *Target amount revisions for the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360)*—(1) *General rule.* For cost reporting periods or any portion of a cost reporting period occurring on or after January 1, 1989 and before January 1, 1990, the intermediary may adjust a hospital's target amount to take into account any distortion in operating costs between the hospital's base period and the period subject to the rate of increase ceiling due to the elimination of part A inpatient hospital benefit limitations under section 101 of the Medicare Catastrophic Coverage Act of 1988 (Pub. L. 100-360).

(2) *Request for adjustment.* A hospital must request an adjustment no later than 180 days after the close of the affected cost reporting period. A request for adjustment must include the following:

(i) A statement from the hospital specifying that the adjustment is to be based on its historical experience in—

(A) Its base period; or

(B) Its last cost reporting period ending before January 1, 1989. (If this period is less than 12 months in duration, multiple

consecutive cost reporting periods comprising at least 12 months must be used.)

(ii) The hospital's cost report or reports for the period selected by the hospital under paragraph (i)(2)(i) of this section to serve as the basis for the adjustment.

(iii) Billing data for the cost reporting period selected under paragraph (i)(2)(i) of this section as the basis for the adjustment documenting the following:

(A) The number of hospital inpatient days furnished to Medicare beneficiaries for which no payment was made because the beneficiary had exhausted part A hospital benefits during an inpatient hospital stay. (Excluded from the count are days for stays that were not covered in their entirety because, prior to admission the beneficiary had exhausted both part A hospital benefits and days in excess of the lifetime limitation on inpatient psychiatric hospital services.)

(B) The number of discharges applicable to Medicare beneficiaries for which no payment was made because the beneficiary had exhausted part A hospital benefits during the hospital stay but in a prior cost reporting period.

(C) The actual charges for ancillary services furnished on the days counted in paragraph (i)(2)(iii)(A) of this section. (A hospital that is unable to document its ancillary charges may substitute average cost per diem for actual charges for ancillary services.)

(3) *Amount of adjustment.* The adjustment is based on the estimated incremental costs of care historically furnished to Medicare beneficiaries after they had exhausted their benefits during an inpatient hospital stay. The adjustment is calculated as follows:

(i) *Step 1* — Determine the average cost per Medicare discharge by dividing the Medicare allowable inpatient operating costs for covered days of care in the base year or the last cost

reporting period ending before January 1, 1989 by the number of Medicare discharges in that cost reporting period.

(ii) *Step 2* — Determine the estimated costs for ancillary services furnished to beneficiaries after exhaustion of part A hospital benefits. (If actual ancillary charges are available, ancillary costs are estimated by applying departmental cost-to-charge ratios from the cost report to the ancillary charges. If actual ancillary charges cannot be retrieved from the hospital's system, an ancillary per diem amount may be used in completing this step.)

(iii) *Step 3* — Determine the estimated routine costs of Medicare inpatient days furnished to beneficiaries after exhaustion of part A hospital benefits (days of care multiplied by the Medicare allowable inpatient operating cost per diem (obtained from the cost report). (No-charge-structure and all-inclusive-rate hospitals use total inpatient operating costs per diem (which equals the Medicare allowable inpatient operating costs in the cost reporting period divided by total Medicare inpatient days).

(iv) *Step* 4 — Determine the total inpatient operating costs for beneficiaries notwithstanding exhaustion of part A hospital benefits (by adding the Medicare allowable inpatient operating costs in the cost reporting period plus the sum of the numbers computed in paragraphs (i)(3)(ii) and (i)(3)(iii) of this section).

(v) *Step 5* — Determine the total number of Medicare discharges notwithstanding exhaustion of part A hospital benefits by adding the number of Medicare discharges for the cost reporting period and the number of discharges for beneficiaries who had exhausted part A hospital benefits in the prior cost reporting period and were discharged during the subsequent period.

(vi) *Step 6* — Determine the average cost per discharge notwithstanding exhaustion of part A hospital benefits by divid-

ing the number computed in paragraph (i)(3)(iv) of this section by the number computed in paragraph (i)(3)(v) of this section.

(vii) *Step 7*—Determine the ratio of average cost per discharge notwithstanding exhaustion of part A hospital benefits to average cost per discharge (by dividing the number computed in paragraph (i)(3)(vi) of this section by the number computed in paragraph (i)(3)(iii) of this section).

(viii) *Step 8*—Determine the adjusted target rate applicable to the discharges in any cost reporting period or portion of a cost reporting period occurring on or after January 1, 1989 and before January 1, 1990 and for discharges occurring on or after January 1, 1990 when admission occurred before that date, by multiplying the updated target rate applicable to the cost reporting period or portion of the cost reporting period occurring on or after January 1, 1989 by the number computed in paragraph (i)(3)(vii) of this section

(ix) *Step 9*—Determine the appropriate target rate for all discharges when admission occurred on or after January 1, 1990, during portions of any cost reporting period occurring on and after January 1, 1990 by updating the hospitals' target rate prior to adjustment pursuant to paragraphs (i)(3)(i) through (i)(3)(viii).

(4) *Time period for determination and notification.* The intermediary notifies the hospital of the adjustment to the target rate for cost reporting periods or any portion of a cost reporting period occurring on or after January 1, 1989 and before January 1, 1990 no later than 90 days after receipt of all data needed to make the determination. An interim adjustment is made if the notice of amount of program reimbursement has not been issued for the period selected under paragraph (i)(2)(i) of this section. If an interim adjustment is made, the intermediary notifies the hospital of the final adjustment to the target rate no later than 30 days after the notice of amount of program reimbursement is

issued for the period selected under paragraph (i)(2)(i) of this section.

(i) *Assignment of a new base period*—(1) *General rule.* (i) Effective with cost reporting periods beginning on or after April 1, 1990, HCFA may assign a new base period to establish a revised ceiling if the new base period is more representative of the reasonable and necessary cost of furnishing inpatient services and all the following conditions apply:

(A) The actual allowable inpatient costs of the hospital in the cost reporting period that would be affected by the revised ceiling exceed the target amount established under paragraph (c) of this section.

(B) The hospital documents that the higher costs are the result of substantial and permanent changes in furnishing patient care services since the base period. In making this determination, HCFA takes into consideration the following factors:

(1) Changes in the services provided by the hospital.

(2) Changes in applicable technologies and medical practices.

(3) Differences in the severity of illness among patients or types of patients served.

(C) The adjustments described in paragraph (g) of this section would not result in recognition of the reasonable and necessary costs of providing inpatient services.

(ii) The revised ceiling is based on the necessary and proper costs incurred during the new base period.

(A) Increases in overhead costs (for example, administrative and general costs and housekeeping costs) are not taken into consideration unless the hospital documents that these increases result from substantial and permanent changes in furnishing patient care services.

(B) In determining whether wage increases are necessary and proper, HCFA takes into consideration whether increases in wages and wage-related costs for hospitals in the labor market area exceed the national average increase.

(2) *New base period.* The new base period is the first cost reporting period that is 12 months or longer that reflects the substantial and permanent change.

(3) *New applicable rate of increase percentages.* The revised ceiling resulting from the assignment of a new base period is increased by the applicable rate of increase percentages described in paragraph (c)(3) of this section.

42 CFR § 413.86(e)

(e) *Determining per resident amounts for the base period. (1) For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, graduate medical education costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and graduate medical education costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.

(B) Divide the costs calculated in paragraph (e)(1)(i)(A) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (e)(1)(i)(A) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

(B) Excludes from the base-period graduate medical education costs any nonallowable or misclassified costs, including those previously allowed under § 412.113(b)(3) of this chapter; and

(C) Upon a hospital's request, includes graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not

allowable under § 412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(2) of this section.

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(iv) If the intermediary modifies a hospital's base-period graduate medical education costs as described in paragraph (e)(l)(ii)(B) of the section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraphs (j)(1) of this section.

(v) The intermediary notifies each hospital that either had direct graduate medical education costs or received indirect education payment in its cost reporting period beginning on or after October 1, 1984 and before October 1, 1985 of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice.

(2) *For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986.* For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(i) If a hospital's base period began on or after October 1, 1983 and before July 1, 1984, the amount is adjusted by the percentage change in the CPI-U that occurred between the hospital's base period and the first cost reporting period to which the provisions of this section apply. The adjusted amount is then increased by one percent.

(ii) If a hospital's base period began on or after July 1, 1984 and before October 1, 1984, the amount is increased by one percent.

(3) *For cost reporting periods beginning on or after July 1, 1986.* For cost reporting periods beginning on or after July 1, 1986, each hospital's per resident amount for the previous cost reporting period is adjusted by the projected change in the CPI-U for the 12-month cost reporting period. This adjustment is subject to revision during the settlement of the cost report to reflect actual changes in the CPI-U that occurred during the cost reporting period.

(4) *Exceptions—(i) Base period for certain hospitals.* If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Any graduate medical education program costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis. The per resident amount is based on the lower of the following:

(A) The hospital's actual costs, incurred in connection with the graduate medical education program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.

(B) The mean value of per resident amounts of hospitals located in the same geographic wage area, as that term is used in the prospective payment system under part 412 of this chapter, for cost reporting periods beginning in the same fiscal years. If there are fewer than three amounts that can be used to calculate the mean value, the intermediary must contact HCFA Central Office for a determination of the appropriate amount to use.

(ii) *Short or long base-period cost reporting periods.* If a hospital's base-period cost reporting period reflects graduate medical education costs for a period that is shorter than 50 weeks or longer than 54 weeks, the intermediary converts the allowable costs for the base period into a daily figure. The daily figure is then multiplied by 365 or 366, as appropriate, to derive the approved per resident amount for a 12-month base-period cost reporting period. If a hospital has two cost reporting periods beginning in the base period, the later period serves as the base-period cost reporting period.

(iii) *Short or long cost reporting periods beginning on or after July 1, 1985.* If a hospital's cost reporting period is shorter than 50 weeks or longer than 54 weeks, the hospital's intermediary should contact HCFA Central Office to receive a special CPI-U adjustment factor.

(2)

No. 94-1122

Supreme Court, U.S.
FILED
FEB 27 1995
OFFICE OF THE CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1994

ST. FRANCIS MEDICAL CENTER, PETITIONER

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

1. Whether the court of appeals correctly held that the Provider Reimbursement Review Board lacked jurisdiction to hear petitioner's Medicare reimbursement claim arising from its 1985 fiscal year cost report because that claim did not meet the $10,000 amount in controversy requirement.

2. Whether the court of appeals correctly held that Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), precludes general federal question jurisdiction over petitioner's Medicare reimbursement claim.

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In the Supreme Court of the United States

OCTOBER TERM, 1994

No. 94-1122

ST. FRANCIS MEDICAL CENTER, PETITIONER

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINIONS BELOW

The opinions of the court of appeals (Pet. App. A1-A20, A21-A38) are reported at 962 F.2d 1110 (*St. Francis I*) and 32 F.3d 805 (*St. Francis II*).[1] The orders of the district court (Pet. App. A39, A52, A55) are unreported.

[1] Petitioner seeks review of two decisions of the court of appeals which arose from the same cause of action in federal district court, and which both involve the same Medicare reimbursement dispute. This Court has jurisdiction to review both decisions, see *Mercer* v. *Theriot*, 377 U.S. 152, 153 (1964).

JURISDICTION

The judgment of the court of appeals (Pet. App. A72-A73) in *St. Francis II* was entered on August 9, 1994. A petition for rehearing was denied on September 27, 1994. Pet. App. A67-A68. The petition for a writ of certiorari was filed on December 23, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

Petitioner St. Francis Medical Center is a provider of health care services covered under Part A of the Medicare Act, Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.* (Medicare Act). Pet. App. A23. Part A provides for the payment of insurance benefits for hospital and related post-hospital medical services. The present dispute arose from petitioner's contention that it has been improperly denied certain Medicare reimbursement payments.

1. The Medicare payments at issue here are made to providers under the cost-based reimbursement system set out by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Pub. L. No. 97-248, 96 Stat. 324 (codified, as amended, at 42 U.S.C. 1395ww(b)).[2] See also 42 U.S.C. 1395f(b) and (x)(v)(1)(A). Pet. App. A23. Under TEFRA, a provider may not receive more than the "target amount" of per patient costs that is calculated according to the provider's actual cost of service in the "base year" (which is the twelve-month reporting period

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[2] In 1983, Congress largely replaced the TEFRA cost-based system with the prospective payment system (PPS), but certain types of hospitals and hospital units are excluded from the PPS. See 42 U.S.C. 1395ww(b) and (d)(1)(A-B). Among the excluded units are distinct rehabilitation units. See 42 U.S.C. 1395ww(d)(1)(B); Pet. App. A6. This case involves such a unit.

immediately before the TEFRA effective date), adjusted in succeeding years by a specified percentage. 42 U.S.C. 1395ww(b)(3)(A); Pet. App. A3-A4. Providers also are eligible for "incentive payments" that reward a hospital for furnishing services to patients at a cost below its TEFRA target amount. Pet. App. A26. Those incentive payments are equal to one-half of the difference between the hospital's yearly costs and the target amount. 42 U.S.C. 1395ww(b); Pet. App. A23-A24.

2. Petitioner operates an acute-care hospital that includes a distinct part rehabilitation unit, and its costs for the unit are reimbursed through the TEFRA cost-reimbursement scheme. Pet. App. A6, A25. For purposes of determining TEFRA reimbursements and incentive payments, petitioner's base year was fiscal year 1985, which ended on June 30, 1985. *Id.* at A6. During fiscal year 1985, Blue Cross and Blue Shield of Western Pennsylvania (Blue Cross/Blue Shield), petitioner's fiscal intermediary,[3] determined that petitioner's rehabilitation unit did not qualify as a distinct part rehabilitation unit under the applicable regulations because less than 75% of the patients in the unit required intensive rehabilitation. *Id.* at A25. In an attempt to meet the 75% requirement for distinct part rehabilitation units, petitioner transferred some of its "non-qualifying" patients—those not requiring intensive rehabilitation—from the rehabilitation unit. *Id.* at A25. That transfer was not completed until June 30, 1986, a full year after the end of petitioner's base-year period. *Ibid.*

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[3] "Fiscal intermediaries" are private organizations that assist the Secretary of Health and Human Services in making Medicare payments and payment determinations. 42 U.S.C. 1395; 42 C.F.R. 421.103.

3. The dispute underlying petitioner's claim is based on petitioner's contention that because the patient transfer was completed after the end of the 1985 base year, some of the non-qualifying patients were included in the base-year cost calculation before they were transferred out of the rehabilitation unit. Pet. App. A6. That resulted, according to petitioner, in "average patient costs * * * higher in 1986 than the estimates of those costs derived from the 1985 base year cost report." *Ibid.*[4] Petitioner contended that the calculation of costs for the base year resulted in the wrongful withholding of almost $2,000,000 in payments for 1986 through 1988. *Id.* at A43.

In an attempt to obtain incentive payments, petitioner sought to adjust its base-year cost report pursuant to 42 C.F.R. 413.40(g) and (h). Pet. App. A7, A24. The Health Care Financing Administration (HCFA) denied petitioner's request for such an adjustment, holding that petitioner's transfer of nonqualifying patients out of the rehabilitation unit after the end of the base year did not constitute "an extraordinary circumstance beyond the hospital's control," which would have justified an adjustment. *Id.* at A7.

Petitioner appealed that decision of HCFA to the Provider Reimbursement Review Board (PRRB). The PRRB, citing 42 U.S.C. 1395*oo*(a) and 42 C.F.R. 405.1835, held that it lacked jurisdiction over petitioner's claim pertaining to fiscal year 1985, because petitioner's request for an adjustment of its base-year cost report did

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[4] In addition, petitioner argued that the base-year cost report erroneously omitted costs for an expansion of the hospital. Pet. App. A6.

not involve an amount in controversy of at least $10,000. Pet. App. A7.[5]

4. Petitioner then filed the present suit in the United States District Court for the Western District of Pennsylvania challenging the jurisdictional ruling by the PRRB. The district court remanded the case to the PRRB, holding that the PRRB had jurisdiction to hear petitioner's claim because it was required to consider the total amount of payments to which petitioner might be entitled between 1985 and 1988 when determining whether the amount in controversy with respect to petitioner's claim met the $10,000 requirement in 42 U.S.C. 1395*oo*(a). Pet. App. A52-A64.

5. The court of appeals reversed, holding that petitioner failed to meet the $10,000 amount-in-controversy requirement. Pet. App. A21-A38. The court noted (*id.* at A30) that 42 U.S.C. 1395*oo*(a)(1)(A)(i) states that the PRRB has jurisdiction over an appeal if the provider is dissatisfied with "the amount of total program reimbursement due to the provider for the items and services furnished to individuals for which payment may be made . . . *for the period covered by such report.*" Consequently, the court concluded that a single provider is not permitted under the applicable statutory provisions and regulations "to aggregate claims over several cost reports in order to satisfy the amount in controversy requirement." Pet. App. A29-A30.

Petitioner contended in the alternative on appeal that if the district court did not have jurisdiction under 42

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[5] However, the PRRB exercised jurisdiction over petitioner's claims for fiscal year 1986. Those claims were settled, resulting in a reimbursement of $1,117,355 to petitioner for full in-patient operating costs for fiscal years 1986 through 1988. Pet. App. A8 n.3.

U.S.C. 1395*oo*, it would have general federal question jurisdiction over the case under 28 U.S.C. 1331. Because that issue had not been raised or addressed below, the court of appeals remanded the case to the district court to afford petitioner the opportunity to amend its complaint to assert jurisdiction under 28 U.S.C. 1331. Pet. App. A33-A34.

6. On remand, petitioner filed a two-count amended complaint. In Count One, petitioner argued that the methodology used by HCFA in reviewing petitioner's application for a base-year adjustment constituted the imposition of an improper reimbursement ceiling. In Count Two, petitioner alleged a violation of its equal protection rights, claiming that it received unfair treatment as compared to providers whose base year cost reports were "undistorted." Pet. App. A10. The Secretary moved to dismiss the amended complaint, arguing that 42 U.S.C. 405(h), which states that no action may be brought to recover on any claim arising under the Social Security Act (of which the Medicare Act is a part) against the United States or any officer thereof under 28 U.S.C. 1331, precluded the exercise of jurisdiction by the district court. The district court granted the motion to dismiss. Pet. App. A39-A51. The court of appeals affirmed, holding that petitioner's claim arises under the Medicare Act and that 42 U.S.C. 405(h) therefore bars jurisdiction in the district court. Pet. App. A1-A20.

ARGUMENT

1. Petitioner first contends (Pet. 15-21) that the reimbursement amounts in years following 1985 that would be affected by the adjustment of its 1985 base-year costs may be combined to satisfy the $10,000 amount-in-controversy requirement for jurisdiction under 42

U.S.C. 1395*oo*. The court of appeals correctly rejected that contention in its first decision. Pet. App. A21-A38.

a. The jurisdiction of the PRRB and the district court to review a Medicare provider's claims in a reimbursement dispute is set out in 42 U.S.C. 1395*oo*. That Section states: "Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by [the PRRB]" if each of several preconditions set forth in 42 U.S.C. 1395*oo*(a)(1)-(3) is satisfied. 42 U.S.C. 1395*oo*(a). As relevant here, paragraph (1) of 42 U.S.C. 1395*oo*(a) states that review by the PRRB is available if the provider "is dissatisfied with the * * * amount of the total program reimbursement due to the provider for the items and services furnished to individuals for which payment may be made * * * for the period covered by such [cost] report." 42 U.S.C. 1395*oo*(a)(1)(A)(i). Paragraph (2) adds the further precondition that "the amount in controversy is $10,000 or more."

The text of these two paragraphs clearly defines the "amount in controversy" in terms of the "amount" of the reimbursement due for the period covered by the particular cost report in question. Nowhere does the Act state that an individual provider may combine the amounts in controversy in each of several distinct cost reporting periods to meet the jurisdictional conditions of 42 U.S.C. 1395*oo*(a). As the court of appeals noted, it is reasonable to assume that if Congress had intended to allow a single provider to aggregate claims over a number of years to provide the jurisdictional amount for a single year's claim, it would have so indicated. Pet. App. A30. That is especially so since 42 U.S.C. 1395*oo*(b) expressly allows another form of aggregation—the combination of the claims of several providers if the total

amount in controversy is $50,000 or more. "In the context of the statute's precisely drawn provisions," the omission of any provision for aggregation of the amounts at issue in different cost reports of a single provider indicates that Congress intended to foreclose that result. *United States* v. *Erika, Inc.*, 456 U.S. 201, 208 (1982).

The legislative history of the Medicare Act supports the conclusion that Congress intended that only a single cost year be considered in assessing whether the $10,000 amount in controversy is satisfied. The House Report, addressing the creation of the PRRB and the amount-in-controversy requirement for single-provider appeals, states:

> Any provider of services which has filed a timely cost report may appeal an adverse final decision of the fiscal intermediary *with respect to the period covered by such a report* to the Board where the amount in controversy is $10,000 or more.

H.R. Rep. No. 231, 92d Cong., 1st Sess. 108 (emphasis added) (1971). Congress obviously contemplated that only a single cost reporting "period" would be considered in determining whether the amount-in-controversy requirement for PRRB jurisdiction is satisfied for a claim based on a single cost "report." *Ibid.*

The regulations promulgated to implement 42 U.S.C. 1395*oo* likewise limit the amount in controversy to claims involving the reporting period covered by the cost report at issue. See 42 C.F.R. 405.1801(a)(1) and (2). The Secretary has consistently followed those regulations in refusing to aggregate the amounts in dispute from multiple cost reports submitted by an individual provider in determining whether the amount-in-controversy requirement has been satisfied. See Pet. App. A32

(citing *Bradner Village* v. *Blue Cross & Blue Shield Ass'n/Blue Cross*, Medicare & Medicaid Guide (CCH) ¶ 38,428, at 22,412 (HCFA Adm'r Dec. Mar. 11, 1990); *Home Call, Inc.* v. *Blue Cross & Blue Shield Ass'n*, Medicare & Medicaid Guide (CCH) ¶ 36,261, at 13,862 (HCFA Adm'r Dec. Feb. 6, 1987)).

In this case, the amount of reimbursement petitioner seeks for base year 1985 is less than $10,000. Indeed, petitioner concedes (Pet. 15) that, absent the sums allegedly due for subsequent years, it does not meet the amount in controversy requirement for its base year claim. Because the statutory language, legislative history, and implementing regulations all indicate that the amount-in-controversy cannot be met by combining amounts of reimbursement allegedly due for several years, the court of appeals properly held that the PRRB (and therefore the district court) did not have jurisdiction under 42 U.S.C. 1395*oo* to entertain petitioner's challenge to the base-year reimbursement report.[6]

b. An additional reason that petitioner's contention must fail is that petitioner did not exhaust its

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[6] Petitioner errs in relying (Pet. 16-19) on the availability of judicial review of the revised base-year costs for graduate medical education expenses in *Methodist Hospitals* v. *Sullivan*, 799 F. Supp. 1210 (D.D.C 1992), rev'd on other grounds *sub nom. Administrators of Tulane Educational Fund* v. *Shalala*, 987 F.2d 790 (D.C. Cir. 1993), cert. denied, 114 S. Ct. 740 (1994). In that case, the provider's cost report for a post-base-year period was reopened pursuant to special statutory provisions, and the base-year costs were recalculated only for purposes of reviewing the reimbursable costs for the reopened cost year. The decision the latter cost report reopening was then appealable to the PRRB and the district in the same manner that an original decision on a cost report may be appealed. *Methodist Hospital* therefore lends no support to petitioner's contention that it may aggregate amounts-in-controversy for two or more different years.

administrative remedies for the years after 1985. The Social Security Act prescribes the exclusive procedures for judicial review of claims, and unless those procedures are followed, judicial review of benefit claims is unavailable. See 42 U.S.C. 405(h); *Heckler* v. *Ringer*, 466 U.S. 602, 606 (1984); *Weinberger* v. *Salfi*, 422 U.S. 749, 757 (1975).

Under the Social Security Act, to meet exhaustion requirements, a claimant must present its claim to the Secretary and exhaust all further applicable administrative remedies. *Ringer*, 466 U.S. at 606-607; *St. Francis Hosp.* v. *Bowen*, 802 F.2d 697, 701 (4th Cir. 1986); see also *Mathews* v. *Eldridge*, 424 U.S. 319, 328 (1976). In cases involving Medicare provider reimbursement disputes, 42 U.S.C. 1395*oo*(f)(1) requires a "final decision" of the Secretary regarding a provider's Medicare reimbursement claim for the specific fiscal year in dispute. A provider then must file separate appeals before the PRRB concerning each individual cost year for which it disputes the Secretary's payment determination. See *Abington Mem. Hosp.* v. *Heckler*, 750 F.2d 242, 244 (3d Cir. 1984) (district court's grant of relief limited to individual claims for reimbursement considered by PRRB), cert. denied, 474 U.S. 863 (1985); *Pacific Coast Medical Enters.* v. *Harris*, 633 F.2d 123, 137-139 (9th Cir. 1980) (court could only hear claim for year properly pending); *Riley Hosp. & Benevolent Ass'n* v. *Bowen*, 804 F.2d 302, 305-306 (5th Cir. 1986) (district court had jurisdiction only over cost reporting periods that had been conclusively ruled upon by PRRB); *Hospital Ass'n* v. *Secretary of Health & Human Servs.*, 820 F.2d 533, 539-540 (1st Cir. 1987) (court did not have jurisdiction to determine additional reimbursement for years beyond the year properly before it).

This case involves only petitioner's appeal to the PRRB with regard to its base year. Although petitioner also appealed to the PRRB with respect to fiscal year 1986, it subsequently settled its claims for the years 1986-1988. Because petitioner abandoned any right of further review, it did not exhaust its administrative remedies for those years. As a result, there was no final decision of the PRRB, other than that for 1985, when petitioner sought judicial review.

2. Petitioner also seeks review of the decision in *St. Francis II*, arguing that "the court of appeals departed from the accepted and usual course of judicial proceedings by affirming [a Rule 12 dismissal] notwithstanding the acknowledged existence of disputed questions of fact." Pet. 22. That claim lacks merit.

The Medicare Act, at 42 U.S.C. 1395ii, incorporates Section 205(h) of the Social Security Act, 42 U.S.C. 405(h). The third sentence of Section 405(h) provides: "No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 1331 or 1346 of title 28 to recover on any claim arising under this subchapter." As this Court has held, "the inquiry in determining whether § 405(h) bars federal-question jurisdiction must be whether the claim 'arises under' the Act." *Ringer*, 466 U.S. at 615. A claim "arises under" the Medicare Act when the Act furnishes "both the standing and the substantive basis for the presentation" of the claim. *Ibid.* (quoting *Salfi*, 422 U.S. at 760-761). Section 405(h) serves to foreclose federal question jurisdiction over both "substantive" and "procedural" claims, as well as for constitutional claims. *Ringer*, 466 U.S. at 615.

Petitioner's claim before the district court in *St. Francis II* unquestionably was a claim "arising under" the Medicare Act. Petitioner alleged that HCFA

imposed an improper ceiling on its Medicare reimbursement. In addition, petitioner sought a judgment directing the Secretary to make additional Medicare payments. Pet. App. A14; compare *Ringer*, 466 U.S. at 614-615.

Petitioner argues (Pet. 23) that the availability of administrative remedies under 42 U.S.C. 1395*oo* in this case presented a disputed question of fact that the district court should have resolved. Pet. 23. The asserted factual dispute, however, was irrelevant to the court of appeals' jurisdictional ruling.

Although the court of appeals acknowledged that petitioners allege that respondent made conflicting statements concerning administrative review, the court correctly concluded that the dispute did not affect the determination of the issue in the case, namely—the availability of jurisdiction for petitioner's claim under 28 U.S.C. 1331. Pet. App. A19.[7] The court explained that because the dispute focused on what the Secretary said about available remedies, and not about what remedies were actually available, the dispute was immaterial to the question of the district court's jurisdiction over petitioner's claim because "[s]ubject matter jurisdiction can never be created by estoppel." Pet. App. A9, citing *Rubin* v. *Buckman*, 727 F.2d 71, 72 (3d Cir. 1984).[8]

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[7] Although petitioner alleges that this aspect of the opinion "has so far departed from the accepted and usual course of proceedings" as to justify review by this court, Pet. 25-26, petitioner fails to dispute the court of appeals' conclusion that the dismissal of petitioner's claim was proper notwithstanding a dispute over an irrelevant factual assertion by petitioner.

[8] Petitioner asserts (Pet. 26) that "[t]he only other way to read *St. Francis II*" is to conclude that it conflicts with *Beverly Hospital* v. *Bowen*, 872 F.2d 483, 486 (D.C. Cir. 1989), creating a

3. Petitioner also contends (Pet. 27-29) that the court of appeals erred by failing to follow this Court's decision in *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986), which concluded that 42 U.S.C. 405(h) did not bar a district court from exercising jurisdiction under 28 U.S.C. 1331 over certain challenges to the administration of Part B of the Medicare program.[9] That contention is meritless.

This Court's ruling in *Michigan Academy* on the applicability of Section 405(h) pertained exclusively to Part B of the Medicare Act. See *Michigan Academy*, 476 U.S. at 680. This Court explicitly contrasted the methods of review in Part A and Part B under the particular statutory provision at issue in that case, 42 U.S.C. 1395ff, which governs the right of Medicare *beneficiaries* (and, under Part B, of the assignees of beneficiaries' claims) to seek judicial review. Section 1395ff provided for judicial review under Part A (subject to an amount-in-controversy requirement), but not under Part B. See 476 U.S. at 675-676. As the court of appeals noted, if this Court in *Michigan Academy* had held that general federal question jurisdiction was lacking, the complaining parties would have had no available avenue

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split in the circuits. Petitioner fails to explain that assertion or provide support for it.

[9] Petitioner suggests that the court of appeals declined to follow *Michigan Academy* on the ground the case is "no longer good law." Pet. 27. Although the court cited *National Kidney Patients Ass'n* v. *Sullivan*, 958 F.2d 1127, 1130 (D.C. Cir. 1992), cert. denied, 113 S. Ct. 966 (1993), which held that *Michigan Academy* was no longer authoritative in light of the 1986 Amendments affecting Medicare Part B, this case involves Part A of the Act.

for challenging the regulation at issue. Pet. App. A16-A17.[10]

After *Michigan Academy* was decided, Congress amended 42 U.S.C. 1395ff to provide for judicial review under part B, if amount-in-controversy requirements are met. See Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9341, 100 Stat. 2037 (codified at 42 U.S.C. 1395ff(b)(1)). Because challenges to regulations and methodologies for determining claims under Part B may be brought pursuant to 42 U.S.C. 1395ff, the courts of appeals have held that general federal question jurisdiction may no longer be invoked under the rationale of *Michigan Academy*, even with respect to Part B claims. See *Farkas* v. *Blue Cross & Blue Shield*, 24 F.3d 853, 860 (6th Cir. 1994); *Abbey* v. *Sullivan*, 978 F.2d 37 (2d Cir. 1992); *National Kidney Patients Ass'n* v. *Sullivan*, 958 F.2d 1127, 1130 (D.C. Cir. 1992), cert. denied, 113 S. Ct. 966 (1993). Petitioner acknowledges (Pet. 28) that the courts of appeals are uniform in their rulings on that point.

Moreover, the present case involves a dispute under Part A of the Medicare Act, which was not governed by *Michigan Academy* in the first place. Just as 42 U.S.C. 1395ff, as in effect at the time of *Michigan Academy*, furnished an avenue for judicial review of Part A beneficiary claims, 42 U.S.C. 1395*oo* now furnishes an avenue for judicial review of Part A provider claims. Thus, the court below correctly concluded:

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[10] Thus, in holding that Section 405(h) did not foreclose federal question jurisdiction over certain challenges under Part B, this Court's disposition avoided the "'serious constitutional question' that would arise if [it] construed [the Section] to deny a judicial forum for constitutional claims arising under Part B of the Medicare program." *Michigan Academy*, 476 U.S. at 681 n.12.

> Since a provider seeking Part A payments has * * * avenues of review available under the Medicare Act, the presumption that Congress did not intend to foreclose judicial review, which was central to the decision in *Michigan Academy*, is inapplicable. And in the absence of that presumption, we read 42 U.S.C. § 405(h), as incorporated into the Medicare Act * * *, to mean that [petitioner] may not assert its claim under 28 U.S.C. § 1331.

Pet. App. A17; accord *Westchester Management Corp.* v. *Department of Health & Human Servs.*, 948 F.2d 279, 282 (6th Cir. 1991), cert. denied, 112 S. Ct. 1936 (1992). The decision below therefore is fully consistent with *Michigan Academy*.

The issue petitioner seeks to raise is, in any event, of no continuing importance. As the court of appeals pointed out (Pet. App. A19), beginning in 1990, a provider may request a new base period that is more representative of the provider's reasonable and necessary costs. See 42 U.S.C. 1395ww(b)(4)(A) and (B) (Supp. V 1993). If the Secretary denies such a request, the provider may then challenge that denial before the PRRB (and, if necessary, the district court) in connection with a challenge under 42 U.S.C. 1395*oo* to the total amount of reimbursement paid for the particular cost period for which the provider contends the Secretary should have calculated its costs by reference to a new base year. That avenue is available to petitioner with respect to any future cost periods, as well as current or past cost periods since 1990 in which petitioner has preserved the issue. See Pet. App. A19-A20. There accordingly is no reason for this Court to grant review to consider petitioner's effort to fashion an alternative avenue of review in an independent suit under

28 U.S.C. 1331 to challenge the Secretary's decision concerning petitioner's 1985 cost year.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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FEBRUARY 1995

Pursuant to Sup. Ct. R. 15.6, Petitioner, St. Francis Medical Center, respectfully submits this Reply to address an argument first raised in a footnote to the Secretary's 2/28/95 Brief in Opposition. The argument raised by the Secretary in this footnote is not only wrong, but is of central importance to this case.

At note 6 of her Brief, the Secretary sets forth a description of *Methodist Hospitals v. Sullivan*, 799 F. Supp. 1210 (D.D.C. 1992), *rev'd on other grounds, Administrators of Tulane Educational Fund v. Shalala*, 987 F.2d 790 (D.C. Cir. 1993), *cert. denied*, 114 S. Ct. 740 (1994) (hereinafter "*Tulane*"). The two sentences in question from the Secretary's Brief state as follows:

> In that case, the provider's cost report for a post-base-year period was reopened pursuant to special statutory provisions, and the base-year costs were recalculated only for purposes of reviewing the reimbursable costs for the reopened cost year. The decision [sic: regarding] the latter cost report reopening was then appealable to the PRRB and the district [sic: court] in the same manner that an original decision on a cost report may be appealed.

See Secretary's 2/28/95 Brief at 9 n.6. This argument is not only inaccurate, but is so inaccurate that it is difficult to comprehend how these two sentences could appear in the Secretary's Brief.

The *Tulane* case did *not* involve an appeal of a post-base-year cost report. Rather, the *Tulane* case involved an appeal of a re-audit adjustment to 1984 "base year" costs. For example, with regard to the "lead" hospital ("Methodist"), the District Court opinion makes crystal clear that the appeal in question involved the re-audit of "Methodist's 1984 cost report." 799 F. Supp. at 1212. The 1984 cost report was the statutory "base period" which was used to determine the "per resident amount" which was the "average amount recognized as reasonable during [the] base period that began in fiscal year 1984 . . . ." 799 F.

Supp. at 1211-12. The amount of the adjustment in issue as a result of the re-audit of the 1984 base year for Methodist was $893,841. *See* 799 F. Supp. at 1212 ("BCBS [the fiscal intermediary] determined that Methodist's allowable GME costs were $893,841 less than the amount determined by the [prior] 1986 audit of Methodist's 1984 cost report"). However, this adjustment amount involved no reimbursement in the base year because the hospital "did not have to refund the difference for 1984 . . . ." 799 F. Supp. at 1212. Rather, this adjustment to the 1984 costs in the amount of $893,841 merely impacted *future* cost years. *Id.* But none of these *future* cost years was on appeal. Rather, the hospital appealed from the notice of the re-audit adjustment related to the 1984 cost year. *Id.* at 1212-13. This appeal was filed pursuant to the 180-day provision set out in the Secretary's regulations. *Id.* at 1212 ("Hospitals, if dissatisfied with the intermediary's determination, have 180 days from the date of notice to file an appeal with the Provider Reimbursement Review Board . . . ."), *citing* 42 C.F.R. § 413.86(e)(1)(v).

In sum, the District Court opinion in *Tulane* makes abundantly clear that the cost report on appeal in that case was not a "cost report for a post-base-year period," as stated at note 6 of the Secretary's 2/28/95 Brief. The Court of Appeal's *Tulane* decision is equally clear on this point. *See* 987 F.2d at 793-94 (referencing the same $893,841 in issue from the 1984 Methodist cost report and similarly stating that the 1984 "reaudits did not result in any recoupment of reimbursements for 1984 *but only affected the base period calculation*") (emphasis added).

In order to ascertain with absolute certainty that *Tulane* involved an appeal of the base year (and not an appeal of a post-base-year cost report), on March 8, 1995, the undersigned counsel contacted Mr. Ronald Sutter, counsel for the provider in *Tulane*. Mr. Sutter confirmed that *Tulane* involved an appeal of the base year, not an appeal of a post-base-year cost report,

and Mr. Sutter supplied the undersigned counsel with copies of pages 110-113 from the Third Circuit Joint Appendix in *Tulane*. Those pages comprise (i) the notice sent by the fiscal intermediary to the provider, and (ii) the provider's notice of appeal to the PRRB. With the knowledge and consent of Mr. Sutter, these documents have now been "lodged" with this Court in this case, *i.e.*, Sup. Ct. Docket No. 94-1122. If the Court wishes to review these materials, the Court will see immediately that the appeal to the PRRB by Methodist was an appeal from a notice regarding the 1984 base year — setting forth the Secretary's determination of the hospital's "average per resident amount . . . for the period ended December 31, 1984" — not an appeal of a post-base-year cost report.[1]

In short, the *Tulane* case did not involve an appeal of a post-base-year cost report. Rather, that case involved a straightforward appeal of an adjustment to base year costs pursuant to the procedure delineated by the Secretary in 42 C.F.R. § 413.86. With regard to Methodist, a *downward* adjustment in the amount

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[1] In addition, if this Court wished to take judicial notice of the briefs submitted to it in connection with the *Tulane* Certiorari Petition, *exactly* the same conclusion would result — both the Petitioner and the Secretary knew that the re-audit of the 1984 cost report was the issue on appeal, *not* a post-base-year cost report, and further knew that no reimbursement amounts in the base year were at issue. *See, e.g.*, Sup. Ct. Docket No. 93-507, Certiorari Petition at 7. *See also* Sup. Ct. Docket No. 93-507, Secretary's Brief in Opposition at 6 and n.3 (referencing the $893,841 at issue from Petitioner's 1984 cost report and further noting that "no recoupment action was taken" regarding the 1984 cost report). Indeed, in her *Tulane* Brief submitted to this Court, the Secretary appeared to argue that a re-audit of the base year costs was the *exclusive* method of proceeding because the Secretary "believed" that there was no provision in the law for "correcting" any base-year errors "later," *i.e.*, in post-base-year appeals. *See* Sup. Ct. Docket No. 93-507, Secretary's Brief In Opposition at 5 ("The Secretary believed that 'the provisions of section 1886(h) of the Act would seem to require that we correct these discrepancies in the base period since there is no provision in the law for correcting them later'"), *citing* 53 Fed. Reg. 36,593 (1988). Copies of these materials are included in the "lodged" materials referenced in the text.

of $893,841 was implemented by the Secretary, but that adjustment concededly had no impact on reimbursement in the base year. Rather, it impacted reimbursement only in future years. Here, of course, St. Francis is seeking an *upward* adjustment to base year costs in an amount "in excess of $700,000." *See St. Francis I*, 962 F.2d at 1113 (Sup. Ct. App. at A-26). Again, it is conceded that this adjustment will have no impact on reimbursement in the base year, but it will impact huge amounts of reimbursement in future years. Thus, from a *jurisdictional* standpoint, *Tulane* and this case are the *same*. If the *Tulane* case had $10,000 or more in controversy, the instant case does as well. Accordingly, the panel in *St. Francis I* was in error when it ruled as follows:

> § 1395oo(a) limits a provider's request for a Board hearing to claims that could result in reimbursement of $10,000 or more due the provider *under the cost report in dispute.*

St. Francis I, 962 F.2d at 1114 (Sup. Ct. App. at A-29) (emphasis added).

By far the most significant aspect of the *Tulane* appeal is that the parties did not merely stumble upon the PRRB appeal process by accident. Rather, the GME appeal process was carefully constructed by the Secretary in 1989. *See* 42 C.F.R. § 413.86(e)(v) (Sup. Ct. App. at A-87). Moreover, the Secretary first constructed and then implemented the GME appeal process during the same period of time (1989-present) that she has been arguing — in *this* case — to the PRRB, the District Court, the Third Circuit and now this Court, that St. Francis cannot appeal the Secretary's denial of the request by St. Francis for a base year adjustment, assertedly because there is no amount in controversy.

The panel decision in *St. Francis I* and the GME appeal process crafted by the Secretary in § 413.86(e)(v) are in complete and total conflict. Tellingly, even though St. Francis argued at length that 42 C.F.R. § 413.86 was wholly at odds with

St. Francis I (see Petition for Certiorari at 16-21), the Secretary has made no attempt to deal with § 413.86 in her 2/28/95 Opposition Brief. Indeed, the Secretary failed even to cite § 413.86. St. Francis submits that the Secretary failed to deal with § 413.86 because she cannot do so — § 413.86 demonstrates conclusively that *St. Francis I* should be reversed.

Respectfully submitted:

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